

**MEDICARE ADVANTAGE HEARING ON PROMOTING
INTEGRATED AND COORDINATED CARE
FOR MEDICARE BENEFICIARIES**

HEARING
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
ONE HUNDRED FIFTEENTH CONGRESS
FIRST SESSION

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**MEDICARE ADVANTAGE HEARING ON
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MEDICARE BENEFICIARIES**

WEDNESDAY, JUNE 7, 2017

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to call, at 1:59 p.m., in Room 1100, Longworth House Office Building, Hon. Pat Tiberi [Chairman of the Subcommittee] presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
Wednesday, June 7, 2017
HL-02

CONTACT: (202) 225-1721

Chairman Tiberi Announces Medicare Advantage Hearing on Promoting Integrated and Coordinated Care for Medicare Beneficiaries

House Ways and Means Health Subcommittee Chairman Pat Tiberi (R-OH), announced today that the Subcommittee will hold a hearing to review the current status of Medicare Advantage programs such as Special Needs Plans, other models like the Program for All-Inclusive Care, and emerging models that allow for increased flexibility and value-based insurance design that are designed to deliver integrated and coordinated care for our most vulnerable seniors and people living with disabilities. **The hearing will take place on Wednesday, June 7, 2017, in room 1100 of the Longworth House Office Building, beginning at 2:00 p.m.**

In view of the limited time to hear witnesses, oral testimony at this hearing will be from invited witnesses only. However, any individual or organization may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit written comments for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, <http://waysandmeans.house.gov>, select “Hearings.” Select the hearing for which you would like to make a submission, and click on the link entitled, “Click here to provide a submission for the record.” Once you have followed the on-line instructions, submit all requested information. ATTACH your submission as a Word document, in compliance with the formatting requirements listed below, **by the close of business on Wednesday, June 21, 2017**. For questions, or if you encounter technical problems, please call (202) 225-3943.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

All submissions and supplementary materials must be submitted in a single document via email, provided in Word format and must not exceed a total of 10 pages. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears. The name, company, address, telephone, and fax numbers of each witness must be included in the body of the email. Please exclude any personal identifiable information in the attached submission.

Failure to follow the formatting requirements may result in the exclusion of a submission. All submissions for the record are final.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202-225-1721 or 202-226-3411 TDD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Note: All Committee advisories and news releases are available at <http://www.waysandmeans.house.gov/>

Chairman TIBERI. The Subcommittee will come to order a minute early, the record will show.

Welcome to the Ways and Means Subcommittee on Health hearing on “Promoting Integrated and Coordinated Care for Medicare Beneficiaries.” It is my pleasure to welcome our four witnesses today as we continue our discussion on the Medicare program and the different integrated care delivery systems offered to our seniors, including those up for extension this year.

The Committee continues to look at ways to reform Medicare and improve the delivery of care for our seniors and people living with disabilities. I think this is a good place to start. It is looking at some of the lessons learned from smaller programs that have offered targeted coordinated care to some of the most frail and sick beneficiaries in our Medicare program.

Today is a great opportunity for us to hear about some of the impediments to providing value-driven care for the population and hear solutions that have not only benefited seniors, but taxpayers as well.

PACE, or the Program for All Inclusive Care for the Elderly, is an integrated care program that provides hands-on long-term care and support to beneficiaries who need an institutional level of care but continue to live at home. Although this program offers seniors and their caregivers a great opportunity to stay in the community and receive the care they need, the criteria for entering a PACE organization remains very restrictive. Additionally, the regulatory and administrative burdens of operating a PACE facility can often make it difficult for PACE organizations to expand and grow to serve more beneficiaries.

Another integrated care option for vulnerable seniors is the special needs plans, or often called SNPs. Congress must act by the end of this year to reauthorize SNPs in order for seniors to continue to have access. Yet, we continue to find challenges surrounding care coordination and delivery in certain types of SNPs.

Due to the lack of integration of benefits and administrative burden of offering a SNP, CareSource, a managed care plan offered in my district, has delayed offering SNPs in their current form. While continuing to offer other insurance products that serve dual-eligible beneficiaries, CareSource finds the integrated model that they are using in northeastern Ohio to be better, more effective, and a more efficient model to serve dual-eligible beneficiaries, one that reduces provider burden and ensures that a patient receives the care and support needed to meet their total healthcare needs.

Today, we will hear from our panel of experts on the benefits and challenges to PACE and SNP operations as well as its enrollees. We will also explore different bipartisan options for changes to these key programs and others within the Medicare Advantage space, such as value-based insurance design, that are needed to increase efficiencies, quality, beneficiary experience, and enrollment.

As the Medicare population continues to grow, it is important that we continue to look at how we can move from volume to value based across all parts of our Medicare program.

Today, we will hear about how we can allow more plan flexibility within the MA space through incentivizing the use of high- versus low-value care and have the potential to lead to lower costs for both taxpayers and beneficiaries while improving health and quality outcomes.

I now yield to our distinguished Ranking Member, Mr. Levin, for the purposes of an opening statement.

Mr. LEVIN. Thank you very much, Mr. Chairman, for holding this hearing.

I would like also, as you did, to thank our witnesses for joining us today. We have an impressive panel that has prepared a number of thoughtful comments and recommendations. I am pleased to see that it includes a fellow Michigander.

This hearing is about new models to coordinate and integrate care for Medicare beneficiaries, especially those who are dually eligible for Medicare and Medicaid. These 11 million Americans are among the most vulnerable members of our society. More than 40 percent are under 65 and live with disabilities and many have very complex healthcare needs. In the past, we have had a bipartisan commitment to providing high-quality care for this population, and hopefully this will continue.

Unfortunately, the recent actions of my Republican colleagues suggest that this may no longer be the case. Last month, the House passed an ACA repeal bill that would slash Medicaid by more than \$800 billion over the next decade, and 2 weeks ago President Trump proposed a budget that would further cut Medicaid by \$600 billion.

These cuts would have a major impact on the people who are the subject of this hearing. Cutting Medicaid will hurt those 11 million Medicare beneficiaries who are dually eligible for both programs and who depend on Medicaid to provide services and cover expenses that Medicare doesn't. For example, Medicaid reduces out-of-pocket costs for low-income beneficiaries and pays for important services that Medicare does not cover, including long-term care.

Ending the ACA's Medicaid expansion and switching to per capita caps or block grants would shift health costs onto beneficiaries and leave many without Medicaid coverage at all. This will reduce access to care and put financial strain on low-income seniors and people with disabilities. I hope we spend time this afternoon discussing this important issue.

We are also here to examine three specific models for delivering care to Medicare Advantage enrollees. Special needs plans are the most prominent of the models we will discuss today. Currently, nearly 2.3 million Americans receive coverage through these plans, which are tailored to the needs of specific populations of bene-

ficiaries. Special needs plans are particularly important to those who are eligible for both Medicare and Medicaid.

Authorization for the program, as you said, Mr. Chairman, expires next year, and I look forward to working in a bipartisan way on an extension that maintains quality while promoting better care and stronger protection for beneficiaries.

We will also discuss PACE. This model has shown promising results by providing coordinated care to frail elderly populations. Although its footprint is small, PACE has allowed thousands of Americans to maintain their independence by providing nursing home-level care in community settings.

As we consider the future of this model, our focus must be on ensuring that quality remains high and that we do not sacrifice our standards in the interest of expansion. This is particularly important now that for-profit enterprises are eligible to participate in PACE.

Both of these models, special needs plans and PACE, help provide care for beneficiaries who are relying not only on Medicare but also on Medicaid.

Finally, we will discuss value-based insurance design, or VBID, a proposal to reduce healthcare costs by promoting high-value care. This model is in its infancy in Medicare, and we still need to learn more about its impacts on the program and on beneficiaries. To be a success, VBID must show meaningful improvements in efficiency without reducing access to necessary services. I hope to hear more from our witnesses, from all of you, about our options for this model moving forward.

Once again, I thank the Chairman and the panel for joining us. And I look forward to very constructive back-and-forth.

Thank you, Mr. Chairman.

Chairman TIBERI. Thank you, Mr. Levin.

Without objection, each of our Members' opening statements will be made part of the record.

With that, I would like to introduce today's witnesses.

First, we will hear from Ms. Gretchen Jacobson, Associate Director of the Program on Medicare Policy at the Kaiser Family Foundation.

Thank you for joining us today.

Next, we will hear from Ms. Cheryl Wilson, Chief Executive Officer at St. Paul's Senior Services.

I appreciate you traveling all the way from California to be with us.

After Cheryl, we will hear from Mr. David Grabowski, a professor at Harvard Medical School and recent MedPAC appointee.

Congratulations, by the way, on that appointment. We look forward to working with you on other Medicare policies that come before this Committee in the future as well.

And last but not least, from what we in Ohio call the State up north, from the school up north, Dr. Mark Fendrick from the University of Michigan.

Is that your son behind you? Is he an Ohio State guy?

Dr. FENDRICK. Michigan State.

Chairman TIBERI. I like that. Very good. I like that.

Mr. LEVIN. Say that again.

Dr. FENDRICK. Michigan State.

Chairman TIBERI. Michigan State. I like Michigan State.

Dr. Fendrick is Director of the Center for Value-Based Insurance Design at the University of Michigan. He is also professor of internal medicine at the School of Medicine and professor of health management and policy at the School of Public Health at the University of Michigan. He received his BA from the University of Pennsylvania, however—that is good—and his MD at Harvard Medical School.

So welcome all of you. As you can notice, I am in a little rush, because we have to go vote.

I think what we will do now, if everyone agrees, we will go vote, we will come back, and then we will hear from Ms. Jacobson and the rest of you shortly. Sorry for the little break. But with this, we are going to break for a little bit, and we will be back.

[Recess.]

Chairman TIBERI. Our hearing will resume, and we will get right to our witnesses.

First up, Ms. Jacobson, again from the Kaiser Family Foundation. You are recognized for 5 minutes.

STATEMENT OF GRETCHEN A. JACOBSON, PH.D., ASSOCIATE DIRECTOR, KAISER FAMILY FOUNDATION'S PROGRAM ON MEDICARE POLICY, WASHINGTON, DC

Ms. JACOBSON. Mr. Chairman and Members of the Subcommittee, I am Dr. Gretchen Jacobson of the Kaiser Family Foundation. I am honored to be here this afternoon to testify on the topic of promoting integrated and coordinated care for Medicare beneficiaries.

Over the years, the Medicare program has developed and continues to test new approaches for integrating and coordinating care for high-cost, high-need Medicare beneficiaries in both Medicare Advantage and traditional Medicare.

My testimony today focuses on three of these approaches: Special Needs Plans, the Program of All-Inclusive Care for the Elderly, or PACE, and Value-Based Insurance Design within Medicare Advantage. Two of three of these approaches focus on people dually eligible for Medicare and Medicaid. The 11 million people who are dually eligible for Medicare and Medicaid comprise about one in five people on Medicare, and these include many of the sickest and frailest people on Medicare.

While most dually eligible beneficiaries are in traditional Medicare, about one-third are in Medicare Advantage plans. This is a similar share to enrollment among other people in Medicare. Among dually eligible beneficiaries in Medicare Advantage plans, about half are in regular Medicare Advantage plans, and the other half are in Special Needs Plans, or SNPs.

SNP enrollment is limited to beneficiaries with specific health conditions or to beneficiaries dually eligible for Medicare and Medicaid. SNPs for dually eligible beneficiaries comprise the largest SNPs and include about 2 million beneficiaries in 2017.

While SNPs have been part of the Medicare Advantage program for over a decade, we know little about what additional services or benefits enrollees receive, how well plans coordinate care for high-

need enrollees, and the outcomes for high-need enrollees compared to other care options.

Like SNPs, PACE programs also receive capitated payments from Medicare. PACE is a provider-based program that was established in the 1970s and is designed for people who need a nursing home level of care but want to continue living in their communities. The extensive literature on PACE suggests that it increases longevity, reduces nursing home care, and reduces hospitalizations and emergency room visits. The biggest challenge with PACE has been its scalability. Most PACE programs are relatively small.

Value-based insurance design is another approach for improving the management of patient care in Medicare Advantage and traditional Medicare. Some have proposed using it to allow Medicare Advantage plans to enhance benefits for enrollees with specific health conditions. This would be a departure from current rules, which require Medicare Advantage plans to provide the same benefit package to all enrollees regardless of their health conditions.

This year, CMS began permitting Medicare Advantage plans to test a value-based insurance design model for specific chronic conditions. My full testimony raises several questions about value-based insurance design, the largest of which is who should really decide which providers and services should be designated as high value?

Overall it is critical to properly evaluate these programs not only because of the growing number of people in them, but also because many of the enrollees are some of the sickest and frailest people on Medicare. It is important to make sure delivery systems are supporting them rather than putting them at risk.

Also, if the programs are shown to be effective, it is worth exploring how to broaden the programs to include other people in Medicare Advantage plans and traditional Medicare with high needs and high costs.

Appropriately managing the care of high-cost high-need Medicare beneficiaries, many of whom are dually eligible for Medicare and Medicaid, could help ensure the fiscal sustainability of both Medicare and Medicaid in the years to come. At the same time, it remains important to ensure that adequate protections are in place to retain access to healthcare services, providers, and quality of care for the sickest and poorest on Medicare.

Thank you, Mr. Chairman. I would be happy to answer any questions, and I look forward to working with all Members and staff of the Subcommittee on these issues in the future.

[The prepared statement of Ms. Jacobson follows:]



**Promoting Integrated and Coordinated Care
for Medicare Beneficiaries**

**Gretchen A. Jacobson, Ph.D.
Associate Director, Program on Medicare Policy**

**Prepared for the Ways & Means Committee
Subcommittee on Health**

June 7, 2017

Chairman Tiberi, Ranking Member Levin, and Honorable Members of the Committee, I am Dr. Gretchen Jacobson, Associate Director of the Program on Medicare Policy at the Kaiser Family Foundation. The Kaiser Family Foundation, based in Menlo Park, Calif., is an independent, nonprofit, and nonpartisan source of facts, analysis and journalism about health care and health policy issues. We have no connection to Kaiser Permanente.

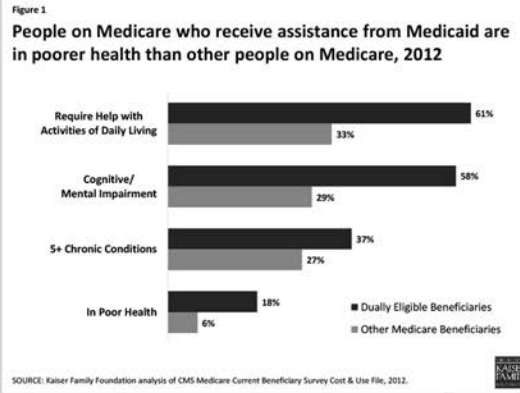
I am honored to be here to testify on the topic of Promoting Integrated and Coordinated Care for Medicare Beneficiaries. Over the years, the Medicare program has developed several approaches for integrating and coordinating care for people who are dually eligible for Medicare and Medicaid, as well as other high-need, high-cost Medicare beneficiaries. My testimony today will focus on three of these approaches: Special Needs Plans, the Program of All-Inclusive Care for the Elderly, and value-based insurance design for beneficiaries who choose to enroll in Medicare Advantage plans. I will highlight the complex health needs of this population and some of the opportunities and challenges presented by these approaches.

People Dually Eligible for Medicare and Medicaid

The 11 million people dually eligible for Medicare and Medicaid (6.5 million seniors and 4.6 million people under the age of 65 with significant disabilities) account for one in five people on Medicare.¹ Most low-income people on Medicare who receive assistance from Medicaid have incomes below the federal poverty level (\$12,060 per year for an individual in 2017) and have little in savings or other assets. By definition, people on Medicare who receive assistance from Medicaid have relatively low incomes, but they also differ from others on Medicare in terms of demographics, medical and long-term care needs, and service utilization. Sixty percent of all dually eligible beneficiaries are women. Fifty percent of dually eligible beneficiaries are younger than 65 with significant disabilities.²

Low-income people on Medicare who receive assistance from Medicaid tend to have more chronic conditions, as well as cognitive and functional limitations, than others on Medicare: about six in ten (61 percent) need assistance with one or more activities of daily living, such as eating, bathing, and dressing; more than half (58 percent) have a mental condition or cognitive impairment; one-third (37 percent) have five or more chronic conditions; and about one in six (18 percent) rate

their health status as poor, more than three times the rate among other people on Medicare (Figure 1).³

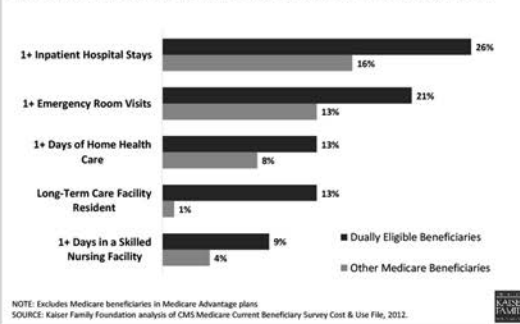


As a result of having greater medical, functional, and cognitive needs, low-income people who are eligible for both Medicare and Medicaid also use more health care services than others on Medicare, including hospital stays, emergency visits, home health care, and skilled nursing facility stays (Figure 2).⁴ With relatively high rates of cognitive and physical limitations, it is not surprising that a substantially larger share of people dually eligible for Medicare and Medicaid live in a

facility, such as a nursing home or mental health facility (13 percent versus 1 percent of other people on Medicare).⁵ Due to their high health care needs, dually eligible beneficiaries face the risk of fragmented care and could benefit from integrated and more closely managed care.

Most dually eligible beneficiaries are in traditional Medicare, and some are in payment and delivery system reform models that are designed to both improve the quality, and lower the costs, of care. The financial alignment demonstrations that several states are undertaking with the Centers for Medicare and Medicaid Services (CMS) are the largest of these efforts targeted to dually eligible beneficiaries.⁶ As of March 2017, more than 392,000 dually eligible beneficiaries were enrolled in these demonstrations.⁷

Figure 2
People on Medicare who receive assistance from Medicaid use more medical services than other people on Medicare, 2012

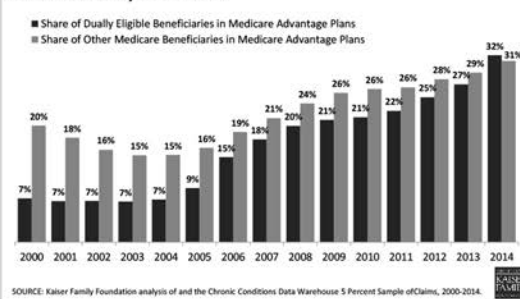


Enrollment of Dually Eligible Beneficiaries in Medicare Advantage Plans

While most people who are dually eligible for Medicare and Medicaid are in traditional Medicare, nearly one in three (32 percent) were in Medicare Advantage plans – a similar percentage as the share of other beneficiaries enrolled in Medicare Advantage plans (Figure 3).⁸ About half of dually eligible beneficiaries in Medicare Advantage plans (1.4 million of 2.8 million) were enrolled in Special Needs Plans (SNPs). Enrollment of dually eligible beneficiaries into Medicare

Advantage plans has increased at a similar rate to the overall growth in Medicare Advantage enrollment.

Figure 3
Enrollment in Medicare Advantage plans has been increasing among beneficiaries dually eligible for Medicare and Medicaid, 2000-2014



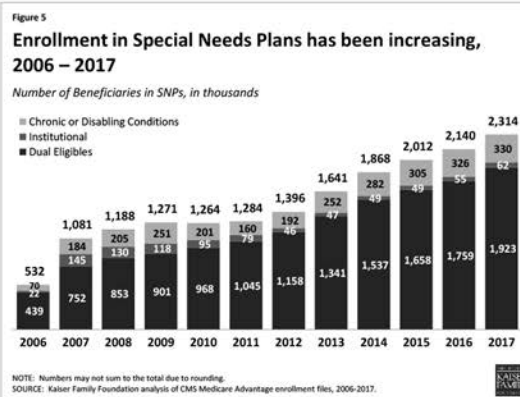
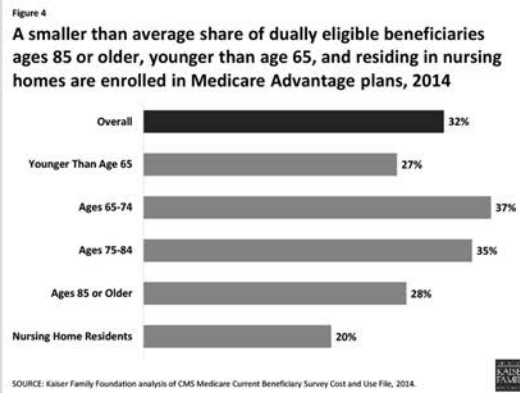
Some dually eligible beneficiaries are under-represented in Medicare Advantage plans. For example, dually eligible beneficiaries who are younger than age 65 and have a significant disability disproportionately do not enroll in Medicare Advantage plans. Only 27 percent of dually eligible beneficiaries under the age of 65 were enrolled in Medicare Advantage plans compared to 37 percent of dually eligible beneficiaries between the ages 65 and 74 in 2014 (Figure 4).

Additionally, only 20 percent of dually eligible beneficiaries who reside in nursing homes and 28 percent of dually eligible beneficiaries ages 85 or older were enrolled in Medicare Advantage plans in 2014.

For the dually eligible beneficiaries enrolled in Medicare Advantage plans that are not SNPs, many questions remain about their care and experience. For example, do Medicaid programs pay the cost-sharing on behalf of dually eligible beneficiaries in Medicare Advantage plans? How well do Medicaid programs coordinate with Medicare Advantage plans in providing Medicaid benefits? What extra benefits do Medicare Advantage plans offer that are attractive to dually eligible beneficiaries?

Special Needs Plans' Role for Dually Eligible and Other Medicare Beneficiaries

Special Needs Plans (SNPs) are a type of Medicare Advantage plan that restricts enrollment to specific types of beneficiaries with significant or relatively specialized care needs. These include beneficiaries who are dually eligible for Medicare and Medicaid (D-SNPs); require a nursing home or institutional level of care (I-SNPs); or have chronic or disabling conditions (C-SNPs). By limiting enrollment to certain high-need beneficiaries, SNPs may be able to develop care management techniques that are tailored to their covered population. In total, 2.3 million Medicare beneficiaries are enrolled in SNPs so far in 2017, including 1.9 million in D-SNPs, about 330,000 in C-SNPs and 62,000 in I-SNPs (Figure 5).⁹



Enrollment of dually eligible beneficiaries in D-SNPs varies greatly by state. In six states, more than one in four dually eligible beneficiaries were enrolled in D-SNPs (AZ, FL, HI, MN, NY, TN), but in nearly half of all states (24 states), 5 percent or fewer dually eligible beneficiaries were enrolled in D-SNPs.¹⁰

SNPs for people with specific chronic conditions, or C-SNPs, are another potential approach for managing the care of high-need, high-cost Medicare beneficiaries. Most C-SNPs focus on the same chronic conditions; 97 percent of people in C-SNPs are in plans that focused on cardiovascular disorders, heart failure, chronic lung disorders, and/or diabetes, in 2017. The minority of C-SNP enrollees (less than 9,000 people) are in plans focusing on other conditions, including 1 percent in plans for people with mental illnesses, 1 percent in plans for people with HIV/AIDS, and 1 percent in plans for people with end-stage renal disease.¹¹

While information is available about how many people are receiving their care through SNPs, little is known about what additional services or benefits enrollees are receiving, how plans are tailored to meet the needs of enrollees, and to what extent the quality of care and outcomes differ across plans. The Medicare Payment Advisory Commission (MedPAC) examined how well SNPs performed on quality measures compared to other Medicare Advantage plans and concluded that, in certain cases, SNPs were better for beneficiaries with special health conditions.¹² The Commission recommended that Congress permanently reauthorize all of the I-SNPs, only D-SNPs that are integrated with Medicaid, and only the C-SNPs that focus on end-stage renal disease, HIV/AIDS, and severe mental illness; the Commission recommended not reauthorizing D-SNPs that are not integrated with Medicaid and C-SNPs that focus on other chronic conditions.¹³

The Role of PACE in the Medicare Program

High-need Medicare beneficiaries also have the option of enrolling in the Program of All-Inclusive Care for the Elderly (PACE) to receive their health care. PACE is a provider-based program that integrates Medicare and Medicaid benefits for people who are dually eligible. People are eligible to enroll in a PACE program if they are 55 or older, require a nursing home level of care, are able to live safely in the community, and live in the service area of a PACE organization. People can enroll in the PACE program if have either Medicare or Medicaid, or both, or if they pay for the program out of pocket. Unlike SNPs, PACE providers have statutory waivers that expand the scope of services they can provide to their enrollees. PACE programs can enroll beneficiaries only on the first day of each month because PACE providers receive a prospective per enrollee payment from Medicare and Medicaid at the beginning of each month.¹⁴

The first PACE program was established in the 1970s, and since that time they have expanded across the country. Currently, there are more than 120 PACE programs. The total number of Medicare beneficiaries enrolled in PACE has more than doubled over the past several years, increasing from almost 17,000 people in 2010 to more than 36,000 in 2017.¹⁵ However, each PACE program tends to be relatively small, and questions have been raised about whether they could be replicated on a larger scale.¹⁶ On average, each program includes 287 Medicare beneficiaries, ranging from less than 20 people to over 2,000 people in 2017.¹⁷

The literature suggests that the PACE program increases longevity, reduces nursing home use, and decreases unnecessary hospital use and emergency room visits.^{18, 19, 20, 21} However, data on the quality of individual PACE programs is not publicly available, making it difficult to assess how quality varies across PACE programs.

MedPAC has made several recommendations regarding PACE programs, such as broadening the eligibility criteria to include people younger than 55,²² developing quality measures for PACE programs, prorating payments to providers to allow beneficiaries to enroll in PACE for a partial month, and establishing an outlier protection policy for PACE providers serving beneficiaries with unusually high costs.²³

Value-Based Insurance Design in the Medicare Advantage Program

Medicare Advantage plans are currently required to offer to all enrollees the same benefit package, regardless of specific enrollees' health status. In the past, the designs of Medicare Advantage plans' benefit packages and cost-sharing were found to discriminate by enrollees' health status by charging more for non-elective services (such as dialysis or Part B-covered drugs) than they charged for more discretionary services (such as physician visits).²⁴ These differences in benefit packages resulted in healthier Medicare beneficiaries selectively enrolling into some plans and sicker beneficiaries enrolling in other plans.²⁵ As a consequence, Medicare Advantage plans' cost-sharing is now more tightly regulated, with limits on cost-sharing for most Medicare Part A and Part B services.

Requiring plans to offer the same benefits to all enrollees may limit plans' ability to selectively enroll healthier beneficiaries, but it may also hinder plans' ability to provide all of the benefits that may aid people with chronic conditions. Value-based insurance design would allow Medicare Advantage plans to enhance benefits for enrollees with specific chronic conditions, and would not require plans to provide those extra benefits to enrollees without those select conditions. This year, CMS began permitting Medicare Advantage plans to test a value-based insurance design model for enrollees with specific chronic conditions. Such a model could be structured to focus on managing the health care of enrollees with high-needs or high-costs or those with less complex chronic conditions.

Medicare Advantage plans are eligible to participate in this CMS model if they operate in one of the seven participating states (AZ, IN, IA, MA, OR, PA, and TN), and meet other eligibility criteria; three more states (AL, MI, and TX) are scheduled to be added to the model in 2018.²⁶ Medicare Advantage plans in these areas must also have at least 2,000 total enrollees in order to participate in the model. Participating plans have several options for enhancing the benefits of enrollees with the target chronic conditions, including reducing cost-sharing for specific services, reducing cost-sharing for specific providers, reducing cost-sharing for enrollees participating in disease management programs, or providing coverage of supplemental benefits.

In 2017, 8 out of 34 firms offering Medicare Advantage plans in the eligible states are participating in the model. These firms are testing the model in three of the seven eligible states (IN, MA, and PA), and all of the firms are focusing the model on enrollees with hypertension, diabetes, chronic obstructive pulmonary disease (COPD), and/or congestive heart failure.²⁷ CMS has not yet reported how these firms are enhancing their plans' benefit packages for enrollees with these conditions.

A value-based insurance design model could provide Medicare Advantage plans the flexibility to tailor their benefits to the needs of their enrollees, providing plans another tool for managing the care of high-need Medicare beneficiaries. However, as with any change in Medicare benefits, oversight is needed. It may be worth examining whether marketing of enhanced benefits could disproportionately attract and reward more educated, highly motivated beneficiaries with the resources to manage their chronic conditions while potentially creating access barriers for less educated, poorer Medicare beneficiaries. If this approach is shown to be effective for people with certain conditions, it may be appropriate to consider how the benefits could be provided more broadly to other beneficiaries with chronic conditions in Medicare Advantage plans or traditional Medicare.

MedPAC has recommended permitting Medicare Advantage plans to use value-based insurance design to enhance benefits for individuals with specific chronic conditions.²⁸ The CMS model that is currently being tested could help to inform the future direction of value-based insurance design in Medicare, if appropriate information is collected and reported about enrollee participation, costs, and outcomes.

Summary

Over 2 million people on Medicare are currently receiving their Medicare benefits through SNPs and the PACE programs. These approaches for integrating and coordinating the care for high-need, high-cost Medicare beneficiaries have the potential to improve the quality of care and outcomes for these beneficiaries. However, given the significant needs of their enrollees, it is important to understand more about how well SNPs and the PACE programs are serving this vulnerable population. In particular, what additional services or benefits are SNPs providing to improve the management of care? How well do D-SNPs coordinate care with state Medicaid programs? What services are I-SNPs providing to the most vulnerable patients in nursing homes, and to what extent are they succeeding in reducing unnecessary hospitalizations? In addition, for both SNPs and PACE programs, how do the quality of care and outcomes vary across plans and programs? These questions are important to answer because of the growing number of vulnerable Medicare beneficiaries covered by these approaches.

Value-based insurance design could be a new model for Medicare Advantage plans to manage the care of either beneficiaries with less complex chronic conditions or high-need, high-cost Medicare beneficiaries. More information would help to clarify how the model might work in practice for these beneficiaries. For instance, what enhanced benefits are plans offering through value-based insurance design? Who should decide what services or providers are high- versus low-value? What protections are needed to ensure that value-based insurance design does not lead to less standardized benefits and more confusion for Medicare beneficiaries? Answers to questions such as these could help inform a thorough evaluation of a value-based insurance design for Medicare Advantage, which is critical given the significant needs of this population.

An additional question to be considered relates to the provider networks available to beneficiaries in SNPs, PACE programs, and Medicare Advantage plans with value-based insurance design models: how do their provider networks affect enrollees' care and health outcomes?²⁹ Limiting access to providers for dually eligible and other high-need beneficiaries could have a large impact on their care.

For dually eligible beneficiaries, Medicaid helps to shield them from unaffordable medical and long-term care costs. Appropriately managing the care of these beneficiaries could help to ensure the fiscal sustainability of both Medicare and Medicaid in the years to come. At the same time, it remains important to ensure adequate protections are in place to retain access to health care services, providers, and high quality care for the sickest and poorest on Medicare.

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Chairman TIBERI. Thank you, Ms. Jacobson.
Ms. Wilson, you are recognized for 5 minutes.

**STATEMENT OF CHERYL WILSON, RN, MA, LNHA, CHIEF
EXECUTIVE OFFICER, ST. PAUL'S SENIOR SERVICES, SAN
DIEGO, CA**

Ms. WILSON. Good afternoon. Thank you, Mr. Chairman Tiberi and Ranking Member Levin and other distinguished Members of the Subcommittee. I am Cheryl Wilson, Chief Executive Officer of St. Paul's Senior Services and St. Paul's PACE in beautiful sunny San Diego. I represent the National PACE Association here today and their 122 PACE organizations with 233 sites in 31 States serving over 42,000 participants each day.

So what is PACE? PACE is the gold standard for integrated care. PACE stands for the Program of All-Inclusive Care for the Elderly, a community-based health and social services provider which receives a capitated payment rate to serve a frail set of Medicare eligible frail seniors all of whom are at nursing home level of care but are still being cared for at home by the PACE team.

We are an insurance company and a care provider. The average participant is 77 years old and lives with multiple chronic, very complex conditions limiting their activities of daily living. Fifty percent have some form of dementia, but through PACE 95 percent live at home. Even more challenging at St. Paul's PACE, 50 percent of those we serve live at home all alone.

Along with our PACE, St. Paul's Senior Services is a full service, nonprofit organization established in 1960. We provide retirement homes, HUD housing, assisted living, memory care, day programs, skilled nursing, and now housing for homeless seniors.

PACE keeps frail seniors in their homes and communities by providing timely, clinically appropriate treatments and social supports. PACE participants experience a high quality of life and optimal medical outcomes with lower costs.

Two weeks ago I had lunch with a lady enrolled in our PACE program. She had all her belongings wrapped securely in a plastic bag. She told me her "other stuff" was outside all wrapped up because of "bugs." She shared with me her multiple major medical conditions and her inability to get out to grocery stores or to her doctors for visits. Thus, she had a history of visiting the emergency room every 2 to 3 months, which she hated because of the long waits, "all the hubbub," and the fact that no one ever spoke to her, rather only about her and over her.

She said she was getting to like the PACE staff, but it was taking time to believe that they could be so nice and really mean it. In fact, this participant had spent the first 3 weeks in PACE sitting outside the building with care being delivered either to her at home or on the bench outside due to her paranoia and fear of exploitation.

She finally agreed to have her home treated for bed bugs and other infestations, to receiving personal care, and to having her belongings wrapped up until she was willing to give them up for 3 days of freezing, which was needed to eliminate all the infestations.

In the meantime this lady was provided with home care, home delivered meals, daily home medications, twice weekly personal

care at the PACE center, weekly physician visits, social services, psychiatric interventions, and many other ancillary services. In the 4 months she has been with PACE, this lady has not experienced a single emergency room visit.

In fact, a study we did showed that in the first year of PACE, patient hospital visits declined 73 percent. PACE serves many frail elders and individuals with disabilities today but we could serve many more. The decades old PACE regulations must be updated immediately. While CMS has issued a proposed rule, it is yet to issue the final rule.

Similarly CMS could support PACE growth by implementing the congressionally granted pilot authority to serve new populations with similar needs and medical complexities. We ask CMS to move the pilots forward quickly.

Other steps forward are some statutory improvements to enable PACE to better serve Medicare beneficiaries. PACE has incorporated many of the reforms promoted by Medicare, including coordinated care and integrated financing. PACE has proven to be a good value to taxpayers. If you haven't visited, please go to visit a PACE site in your State, and if you don't have a PACE site, ask why.

In all my years in healthcare I know that PACE is the very best model of care as professed to me by Health and Human Services Secretary Tommy Thompson over 15 years ago.

Thank you for listening to me, and I look forward to answering your questions.

[The prepared statement of Ms. Wilson follows:]



**Statement of Cheryl Wilson, RN, MA, LNHA
Chief Executive Officer
St. Paul's Senior Services
San Diego, California
On behalf of the National PACE Association**

**Before the Ways and Means Health Subcommittee
U.S. House of Representatives
Hearing on Promoting Integrated and Coordinated
Care for Medicare Beneficiaries
June 7, 2017
2:00 p.m.**

Chairman Tiberi, Ranking Member Levin, and distinguished members of the Subcommittee, thank you for holding today's hearing examining integrated and coordinated care. I am Cheryl Wilson, CEO of St. Paul's Senior Services, and St. Paul's PACE, located in San Diego, California. It is my privilege to come before you representing the National PACE Association, the 122 PACE organizations operating in 31 states, and the over 42,000 participants we serve each day. Having trained and worked in healthcare all over the world since 1966, I am convinced that case management care models for Medicare beneficiaries with complex medical and functional support needs are essential to supporting their quality of life.

PACE is shorthand for Program of All Inclusive Care for the Elderly. PACE is a proven care model delivering high-quality, comprehensive, integrated and coordinated community-based care to Medicare beneficiaries 55 years of age or older, who meet the criteria for a nursing home level of care, but wish to live at home. Multiple studies show that people receiving care from PACE organizations live longer, experience better health, have fewer hospitalizations and spend more time living at home than those receiving care through other programs.

My testimony will cover three main points: a brief discussion of the PACE program; the benefits of PACE to the people it serves; and recommendations to remove obstacles currently impeding the future growth of PACE and the number of Medicare beneficiaries that can be served.

Overview of the PACE Program

The PACE model has existed in Medicare since 1983, initially as a pilot program. PACE became a permanent part of the Medicare program and a Medicaid state option in 1997 through the Balanced Budget Act (P.L. 105-33). PACE is a comprehensive, fully integrated, provider-based health plan. It was deliberately designed to address the health care needs of a medically complex and costly subset of Medicare beneficiaries – adults age 55 and over who meet state eligibility requirements for a nursing home level of care. The PACE care model was first developed in 1971 by an organization called On Lok in San Francisco in my home state of California. PACE continues to operate based on the fundamental principle that it is preferable in terms of quality of life, quality of care, and costs to public and private payers for PACE-eligible individuals to be served in the community whenever possible.

PACE organizations enroll an exclusively high-risk, high-cost population comprised of seniors and people living with disabilities at a nursing home level of care. Of the approximately 42,000 individuals served by PACE organizations across the country, 85 percent are at least 65 years of age, with 15 percent between the ages of 55 and 64. The average age across all participants is 77. PACE enrollees live with multiple chronic, medically complex conditions. The most common conditions that PACE participants experience are: vascular disease; diabetes with chronic complications; congestive heart failure; chronic obstructive pulmonary disease; and major depressive, bipolar and paranoid disorders. Additionally, almost half of all participants have some form of dementia. A large majority of PACE participants (86 percent) are unable to carry out one or more activities of daily living (ADL) without assistance, such as bathing, dressing, eating, toileting, transferring, and walking. Almost 60 percent of PACE participants need help with at least three ADLs. Despite their frailty and medical complexity, PACE participants enjoy a high quality of care and quality of life. Ninety-five percent live at home in their communities. Fifty percent of the individuals we serve through St. Paul's PACE live alone at home.

At the heart of the PACE model of care is a unique interdisciplinary team (IDT) comprised of a wide range of health care professionals including primary care providers, nurses, social workers, rehabilitative and recreational therapists, dietitians, personal care aides, and drivers. The members of the IDT have a direct care relationship with the Medicare beneficiaries they serve. This enables the team to very quickly and effectively identify, plan for, and respond to the complex medical care and functional support needs of the people they serve. Meeting daily, the IDT works collaboratively with program participants and their families to develop individualized, person-centered care plans addressing the full spectrum of participants' medical, long term service and support, and other biopsychosocial needs. The PACE organization is responsible for implementing these care plans across all settings of care, including at home, in community-based settings, and in inpatient acute care and nursing facilities, on a 24/7 basis, 365 days a year.

PACE organizations operate PACE Centers where program participants receive a broad range of services from multiple professional practitioners with extensive expertise in geriatrics. At the PACE Center, participants receive primary medical care, nursing services, rehabilitative therapy services (including occupational therapy, physical therapy, and speech therapy), social work services, personal care and supportive services, nutritional counseling; engage in activities; and are provided with meals. Because PACE organizations provide care directly to program enrollees, PACE organizations expand and improve on other services available in the community, which often are lacking and inaccessible to PACE's frail, elderly population. In addition, PACE organizations provide care in the home and transportation services to other providers in the community to address the needs of their enrollees. PACE organizations contract for services that they do not directly provide, such as inpatient hospital, nursing facility, and specialist care.

With the responsibility to provide and pay for the entire continuum of medical care and long-term services and supports required by frail elders and those adults living with disabilities, PACE pays for all Medicare Parts A, B and D benefits, all Medicaid-covered benefits, as well as any other services or supports that are necessary to maintain or improve the health status of PACE program participants. Ninety percent of participants are dually eligible for Medicare and Medicaid.

For Medicare-funded services, PACE organizations are paid a capitated (per person, per month) monthly rate. This payment model rewards effective provision of preventive care, primary care, and community-based long term services and supports to minimize the need for avoidable, high-cost institutional care. The PACE program has proven to be a good value to taxpayers. A recent study by Mathematica Policy Research (MPR) determined that PACE costs are comparable to the cost of other Medicare options, but that PACE provides better quality of care for this extremely frail, complex population. Notably, the MPR study determined that PACE enrollees had a lower mortality rate than comparable individuals either in nursing facilities or receiving home and community based services (HCBS) through waiver programs.

PACE at St. Paul's

St. Paul's has operated a PACE program serving the San Diego community since 2008. We currently serve over 600 individuals, with a new PACE center under development. In addition to our PACE services, St. Paul's Senior Services is a full-service, nonprofit retirement organization providing homes and care to generations of San Diego's seniors since 1960. We provide affordable, innovative and

comprehensive programs in a non-denominational environment with great value placed on optimal independence at all stages of life. With the changing needs of today's older adults, our services have expanded to bring innovative choices to those seeking active retirement living, personal care, memory support, and medical care.

We continually provide for excellent, cost-effective and affordable services that will encourage and enrich independent living, including PACE. Through its interdisciplinary approach, which is the hallmark of PACE, St. Paul's seeks to provide care that addresses the varied social, physical, and spiritual needs of those we serve. St. Paul's Senior Services started with HUD housing, and this week opened our third Homeless Senior Housing project where PACE provides all the medical and social care. Our retention rate in these programs is 97 percent. Significantly, the primary reason for seniors dis-enrolling from our PACE program is that their health has improved to the point where they no longer meet the state's criteria for a nursing home level of care, and therefore are not eligible to remain in the program. Regrettably, for some, when they no longer have access to our PACE services, this displacement results in a decline in their health.

Benefits of PACE

When individuals with chronic and medically complex conditions do not have access to care, their quality of life is diminished, which over time leads to increased expenditures. PACE deliberately was constructed to address the chronic care needs of individuals by providing timely and clinically appropriate treatments and social supports. Access to care in PACE results in our participants not only experiencing a higher quality of life, but also having medical outcomes meeting the highest standards. Moreover, by reducing the incidence of complications associated with chronic illness, PACE programs also reduce the high costs of specialists, emergency rooms, and hospitals incurred in response to these complications.

Two weeks ago, quite by accident, I had lunch with a lady enrolled in our PACE program. This lady had all her belongings wrapped securely in a plastic bag. She told me her other "stuff" was outside all wrapped up because of "bugs." As we ate lunch together she told me her story which included a description of her multiple, major medical conditions, and her inability to manage as she could not get out to grocery stores or to her doctors for visits. As a result, she had a history of visiting the emergency room every two to three months, which she hated because of the long waits on a "skinny" bed which were uncomfortable due to her weight, all the hubbub, and the fact that no one ever spoke to her—they spoke about her and over her. She said she was getting to like the PACE staff, but it was taking time to believe that they could be so nice and really mean it. Further conversations with staff revealed this lady had spent the first three weeks in PACE sitting outside the building with care being delivered either to her home or on the bench outside due to her paranoia and fear of exploitation. She had finally agreed to have her home treated for bed bugs and other infestations, to receiving personal care, such as bathing and grooming from nursing staff, and to having her belongings wrapped up until she was willing to give them up for three days of freezing to eliminate all infestations. In the meantime, this lady is provided with dietetically appropriate meals delivered to her, daily home care for medication management, twice weekly personal care treatments at the PACE center, weekly physician visits, social services and

psychiatric interventions, and many other ancillary services. In the four months she has been with PACE, this lady has not experienced a single emergency room visit.

This has been our general experience with our participants regarding hospital visits. A study we performed internally at St. Paul's showed that, once enrolled in PACE, visits and admissions to the hospitals were reduced by 73 percent in the first year of PACE enrollment. These results are for our elders who average seven major chronic conditions each and who live in poverty.

These findings have been correlated by other studies of PACE programs across the country; in Massachusetts and Wisconsin, state level studies observed that PACE participants had fewer emergency department visits. Moreover, those same studies, along with others conducted in Texas and New York, reported fewer hospital admissions for PACE participants and shorter hospital stays for those who were admitted. Further, a study of PACE participants in South Carolina found that "PACE participants had a substantial long-term survival advantage compared with aged and disabled waiver clients." This finding is supported by a national study which found that PACE participants had a considerably lower mortality rate than individuals in nursing homes or home and community based services provided by state Medicaid waiver programs

Providing effective and timely chronic care helps people live longer, avoid hospitalizations, and experience a higher quality of life with better health outcomes. In a 2010 study by Chad Boulton and Darryl Wieland, PACE is highlighted as one of three chronic care models that include processes to improve the effectiveness and efficiency of complex primary care. In the PACE care model, we are achieving these results for less than, or the same costs as other programs. In Medicare, payments to PACE organizations are equivalent to the costs for a comparable population receiving services through the fee-for-service program. In Medicaid, states pay PACE programs on average 16.5% less than the costs of caring for a comparable population through other Medicaid services, including nursing homes and home and community-based waiver programs.

As a comprehensive and capitated model, PACE incorporates the features of value based insurance design (VBID). By being fully at risk for all care and the associated costs of that care, PACE's financial incentives are aligned with improving health and independence and reducing higher costs of care. By maintaining individuals at the highest possible level of health and independence through the provision of preventive and primary care, long term services and supports, and comprehensive care coordination, PACE organizations reduce the use of high cost acute care and institutional care settings. Equally, as a provider-based model, PACE organizations link personal assessments and care planning with the integrated delivery of services. This direct care relationship with the people PACE serves allows for continuous evaluation of participants' conditions and revisions to their care plans in response to ever changing medical needs.

The Center for Medicare and Medicaid Services (CMS) is currently in the process of specifying a national set of quality measures for PACE; NPA is supportive of this effort. In the meantime, we have proposed a core set of measures and undertaken several quality initiatives on our own. These NPA initiatives include the development of a national benchmarking data set, as well as two national quality improvement studies addressing behavioral health services and needs, and place of death for PACE participants.

At St. Paul's, I have seen new members come into the program who were living under squalid conditions and who had been wheelchair bound for 3-5 years. These people had no house cleaning or bathroom access, no access to grocery stores, not enough money to purchase medicines, no ability to return for routine physician visits, and no routine immunizations ('flu etc.). Our first member in 2008, was a university professor who had lost everything including his home, health, dignity and self-worth due to costs of cancer care. After enrolling in PACE, he lived happily within our PACE family for 8 years, often being a spokesperson at public meetings. Another homeless lady with multiple medical conditions was referred to us by the emergency room social worker as a "frequent flyer" and, after housing her in one of our facilities, her PACE team restored her health so much that she could fly to Sacramento, accompanied by a staff person, to advocate for affordable housing for seniors. She testified before the California legislature and was very well received.

Many PACE families have told me they can resume employment, and start to care for their own health as well as the well-being of their younger family members due to PACE services returning ambulation and managing the health for their loved one. Additionally, our family surveys show a 96 percent satisfaction rate with all care.

PACE Moving Forward

NPA and our member organizations wish to assist the Medicare program to address the expanding number of Medicare beneficiaries with complex medical and functional support needs. Demands on the American health care system and, in particular, Medicare will be drastically increased due to notable, impending demographic shifts. The Medicare Payment Advisory Commission (MedPAC) reported in 2015 that starting in 2011, roughly 10,000 baby boomers became Medicare beneficiaries each day with that growth rate projected to last until 2030. Furthermore, MedPAC estimated that these additional beneficiaries will cause a 50 percent increase in the Medicare program's population from 2015 to 2030, jumping from 54 million to over 80 million. Many of those beneficiaries are likely to be high cost and high need. An AARP estimate found that over the lifespan of those 65 years of age and older, there is a 68 percent probability of either experiencing cognitive impairment or requiring assistance with at least two ADLs. Leading Age observed that there is a 70 percent chance of Americans of Medicare age (65+) needing some form of long term services and supports. Americans have expressed clear preferences as to the setting in which they would like to receive this care. A 2016 poll conducted by the Associated Press and the NORC Center for Public Affairs Research found for adults 40 years of age and older, 77 percent prefer to receive any necessary long term care services in their home.

From its inception, PACE has incorporated many of the health care delivery system features that the Medicare program seeks to promote, including person-centered care, health homes, coordinated care, and integrated financing. Thus, PACE is a well-suited, sustainable option for meeting the care needs and setting preferences of medically complex Medicare beneficiaries who need a nursing home level of care. PACE's community-based, provider-directed, person-centered, and cost effective model of care is effectively serving many frail elders and individuals with disabilities today, and could serve many more in the future. However, challenges and obstacles exist, which inhibit the ability of the PACE program to expand and serve more Medicare beneficiaries.

Significant regulatory challenges need to be addressed. Updating the current PACE regulation, which is now over a decade old, must be done immediately. While CMS has issued a proposed rule that would provide PACE with more operational flexibility, it has yet to implement this rule in final form. As a result, PACE organizations face operational and administrative requirements that constrain growth. In its comments to CMS on the proposed PACE rule (CMS-4168-P), NPA has stressed the need for more flexibility to:

- Allow PACE organizations, in addition to operating a PACE Center, the option to offer and oversee services in other settings (e.g., adult day health centers, senior centers) that support the interaction of PACE participants with one another and with PACE interdisciplinary team members;
- Include community physicians as members of the PACE interdisciplinary team;
- Utilize Nurse Practitioners and Physician Assistants as primary care providers; and
- Provide operational flexibility to configure the PACE interdisciplinary team based on the needs of individual participants.

The proposed rule was issued on August 16, 2016 and the comment period for the rule closed on October 17, 2016. It now has been over seven months since the close of the comment period. We respectfully request CMS to conclude its consideration of the comments and move forward to implement a revised regulation that provides PACE organizations with the operational flexibility needed to grow and serve more frail seniors and those living with disabilities.

Similarly, CMS can support PACE growth by implementing the pilot authority provided by Congress to allow PACE to serve new populations with similar needs and medical complexities to the population currently served. On October 21, 2015, Congress passed the PACE Pilot Act with unanimous, bipartisan support. In response, on December 23, 2016, CMS released a request for information (RFI) to develop PACE pilots for new populations. Through the RFI, CMS requested information on the design and future implementation of a broad range of PACE pilots. The RFI provided the greatest detail regarding a five-year pilot (the Person Centered Community Care Model, P3C) for people with physical mobility impairments, while also seeking input on potential pilots for individuals with other needs, including but not limited to, people with intellectual and developmental disabilities, and individuals with complex medical and functional support needs who are at risk of needing a nursing home level of care. The comment period for the RFI closed on February 10, 2017. To date, CMS has not moved forward to incorporate those comments into an announcement of PACE pilots. We ask CMS to move forward with the PACE pilots.

Other obstacles to Medicare beneficiaries access to PACE require Congressional action. NPA recommends the following legislative changes to the PACE program to eliminate impediments and facilitate increased access to this proven model of care for Medicare beneficiaries.

- *Allow Medicare-Only Beneficiaries Who Enroll in PACE to Choose a Distinct Part D Plan, Rather Than Requiring Them to Enroll in the Part D Plan of the PACE Organization*

PACE is required to provide all Medicare and Medicaid benefits to a participant. Therefore, a Medicare-only beneficiary is limited to the Part D plan offered by the PACE program for prescription drug

coverage. Unlike dually-eligible beneficiaries, Medicare-only beneficiaries must pay a monthly premium for Part D coverage. As such, they should have the freedom to select the Part D plan of their choice. Greater selection and flexibility is critical so that Medicare beneficiaries may receive the Part D coverage best suited to their medical and financial needs.

- *Allow PACE Organizations More Flexibility in Determining the Premiums Charged to Medicare-Only Beneficiaries*

Existing regulations limit the ability of PACE organizations to establish the premiums charged to Medicare-only beneficiaries since the amounts must be set in accordance with the Medicaid rates paid for dual-eligible beneficiaries. This requirement unduly limits the ability of PACE organizations to set premiums accounting for differences in care needs existing among a nursing home-eligible population. With few exceptions, PACE Medicaid rates for dually-eligible individuals are not adjusted for risk or need.

- *Authorize PACE Organizations in States Without PACE to Move Forward Under a Contract with Medicare*

Currently, PACE organizations can operate only in states that have added the PACE program to their Medicaid plans and agree to enter into three-way PACE program agreements with PACE organizations, the State, and CMS. To date, 19 states have not elected PACE as a state option, so Medicare beneficiaries do not have access to the program in those states.

Conclusion

Thank you, Chairman Tiberi and Ranking Member Levin, and members of the Subcommittee for the opportunity to share the achievements of the PACE program today with the Subcommittee. St. Paul's and the 121 other PACE programs with 233 PACE centers across the nation have a proven track record of providing high quality, coordinated, integrated and cost-effective care to beneficiaries requiring a nursing home level of care-- one of the frailest and most medically complex segments of the Medicare population. NPA and its membership is committed to working with you to surmount the identified obstacles to growth, so that in the future more Medicare beneficiaries who would benefit from enrollment in PACE will have access to the program where they will receive cost-effective, comprehensive care.

In all my years in health care, I agree that PACE is the very best model of care as professed to me by HHS Secretary Tommy Thomson over 15 years ago.

I look forward to answering any questions.

Chairman TIBERI. Thank you. Mr. Grabowski, you are recognized for 5 minutes.

STATEMENT OF DAVID C. GRABOWSKI, PH.D., PROFESSOR OF HEALTH CARE POLICY, DEPARTMENT OF HEALTH CARE POLICY AT HARVARD MEDICAL SCHOOL, BOSTON, MA

Mr. GRABOWSKI. Great. Thank you. Good afternoon. My name is David Grabowski, and I am a professor in the Department of Health Care Policy at Harvard Medical School.

I would like to thank Chairman Tiberi, Ranking Member Levin, and the distinguished Members of the Committee for giving me this opportunity to speak today.

This testimony is derived in large part from the academic work I have done related to integrated and coordinated care for Medicare beneficiaries. Before I begin my substantive remarks, I would like to emphasize that my comments reflect solely my beliefs and do not reflect the opinions of any organization I am affiliated with, including MedPAC, which I was just appointed to last month.

Mr. Chairman, we all share the policy goal of coordinated, high-value care for dual eligible and chronically ill Medicare beneficiaries. Under traditional Medicare fee-for-service dual eligible beneficiaries have three health insurance cards, Medicare Part D, and Medicaid, with three very different sets of benefits.

Ultimately this fragmented model of coverage does little to encourage cost containment or high-quality care. Under an integrated model of care, enrollees ideally have a single set of comprehensive benefits covering a range of services. They have an individualized care plan with a coordinated team of health providers that encourages care in less restrictive, lower-cost settings.

Medicare Advantage Special Needs Plans, or SNPs as they are called, are one potential way to achieve this type of financial and clinical integration. SNPs were authorized in 2003 with the idea of attracting a different type of beneficiary into Medicare Advantage. Today over 2 million individuals are enrolled in SNPs, which is greater than the number of Medicare beneficiaries in all other integrated care programs combined.

SNPs enjoy some unique regulatory advantages. As such, it is vitally important that we understand whether there is anything truly special about Special Needs Plans to justify their unique status.

Two areas where SNPs have the opportunity to provide benefits are through improved quality, and better integration. In terms of quality, the research is somewhat mixed when comparing SNPs with traditional Medicare Advantage plans. The findings depend on the type of SNP. Institutional SNPs, or I-SNPs, perform better than other plans on the available quality measures. Dual eligible, or D-SNPs, perform better when they are strongly integrated with Medicaid but very similar to other plans when less well integrated.

Finally, Chronic Conditions SNPs, or C-SNPs, generally perform no better, and often worse, when compared to other plans.

In terms of integration, if the dual eligible SNPs are going to offer a truly integrated product, they need to both clinically and financially integrate with Medicaid.

As a bit of history, the first generation of D-SNPs had little integration with Medicaid. Beginning in 2008, the D-SNPs were required to have a contract with Medicaid. In response, most D-SNPs simply established a contract for case management of Medicaid services. Today most D-SNPs are still not at risk for Medicaid spending or accountable for Medicaid outcomes. This is not true integration.

Moving forward, Mr. Chairman, I want to highlight four areas of opportunity for Medicare policy.

First, all D-SNPs should be both clinically and financially integrated with Medicaid, otherwise it is hard to make a case for this model over regular MA plans.

Second, SNPs must show that they offer higher quality to beneficiaries. If certain models like C-SNPs do not generally perform better than regular Medicare Advantage plans, we need to reconsider whether this model is working for beneficiaries.

Third, payments to SNPs for those full duals should be commensurate with the cost of covering these individuals. Historically risk adjustment has not properly accounted for the frailest beneficiaries. CMS recently adjusted payments upward for the full duals to address this issue. I would encourage continued oversight on the adequacy of payments and risk adjustment.

Finally, relative to other models like PACE and the V-BID demonstration, SNPs have not been comprehensively studied by CMS in over a decade. If we are going to continue to put public dollars into this program we need a more rigorous and nuanced understanding of which SNP models work for which Medicare beneficiaries.

In summary, the theory of integrated care underlying the SNPs is incredibly compelling. In practice, however, we have not achieved meaningful integration in a majority of SNPs to date. Reforms that encourage true integration will help ensure high-value care for our frailest Medicare beneficiaries.

Thank you, Mr. Chairman. I look forward to your questions.

[The prepared statement of Mr. Grabowski follows:]

Promoting Integrated and Coordinated Care for Medicare Beneficiaries

David C. Grabowski, PhD
Professor of Health Care Policy
Harvard Medical School
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Testimony before the Subcommittee on Health
of the House Committee on Ways and Means

June 7, 2017

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June 7, 2017
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My name is David Grabowski, and I am a Professor in the Department of Health Care Policy at Harvard Medical School. I would like to thank Chairman Tiberi, Ranking Member Levin, and the Distinguished Members of the Committee for giving me the opportunity to speak today about integrated and coordinated care for Medicare beneficiaries. This testimony is derived in large part from the academic work I have done related to this issue.¹⁻⁵ Before I begin my substantive remarks, I would like to emphasize that my comments reflect solely my beliefs and do not reflect the opinions of any organization I am affiliated with, including MedPAC which I was appointed to last month.

A long-standing policy goal has been the development of coverage models that promote coordinated, high-value care for dual-eligible and chronically ill Medicare beneficiaries. Unfortunately, the traditional fee-for-service payment system has not typically achieved this objective. Dual eligible beneficiaries have three health insurance cards (Medicare, Part D, and Medicaid) with three different sets of benefits. Given this bifurcated coverage under Medicare and Medicaid, each program has the narrow interest in limiting its share of costs, and neither program has an incentive to take responsibility for care management or quality of care. Ultimately, this fragmented model of coverage does little to encourage cost containment or high quality care.

Under an integrated model of care, enrollees ideally have a single set of comprehensive benefits covering a range of services including physician, hospital, prescription drug, and long-term care services. They have an individualized care plan with a coordinated team of health providers. The hope is that this integrated care can be delivered in lower-cost community settings, which is consistent with most beneficiaries' preferences.

One model that has the potential to financially and clinically integrate services is the Medicare Advantage Special Needs Plans (SNPs). SNPs were authorized under the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, with the idea of attracting a different type of beneficiary into Medicare Advantage. SNPs target one of three types of beneficiaries: Medicare-Medicaid eligible enrollees via dual eligible SNPs (D-SNPs), individuals residing in nursing homes or in the community who are nursing home certifiable via institutional SNPs (I-SNPs), and individuals with severe or disabling chronic conditions via the chronic condition SNPs (C-SNPs).

Today, over 2 million Medicare beneficiaries are enrolled in SNPs, which is greater than the number of Medicare beneficiaries in all other integrated care programs combined. SNPs enjoy some unique regulatory advantages over regular Medicare Advantage plans such as special month-to-month enrollment rules. Thus, it is vitally important that we understand whether there is anything "special" about special needs plans to justify their unique status.⁶ Two areas where SNPs have the opportunity to provide benefits are through improved quality and better integration.

In terms of quality, my early research² and separate work⁷ commissioned by the Centers for Medicare and Medicaid Services (CMS) generally did not find that special needs plans offered better quality when compared to regular Medicare Advantage plans. This research raised the

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question of whether SNPs offer value to beneficiaries above traditional Medicare Advantage plans. The CMS-commissioned work suggested quality was relatively better in D-SNPs and I-SNPs compared with C-SNPs. Recent analyses conducted by MedPAC⁸ suggest better performance in the D-SNPs and I-SNPs relative to traditional Medicare Advantage plans. However, MedPAC has found that the C-SNPs generally perform similar—or even worse—relative to regular Medicare Advantage plans.

In terms of integration, if the D-SNPs are going to offer a true integrated product, they need to clinically and financially integrate with Medicaid. As a bit of history, the first generation of D-SNPs had little relationship with Medicaid. They basically acted like a regular Medicare Advantage plan. Congress recognized this issue and required SNPs under the Medicare Improvement for Patients and Providers Act (MIPPA) of 2008 to have a contract with Medicaid. This was a *necessary* step towards encouraging integration but unfortunately it was not *sufficient* towards ensuring meaningful integration.

In response to MIPPA, D-SNPs have established contracts to coordinate Medicaid long-term care and behavioral health services for the beneficiary. However, most D-SNPs do not actually cover these Medicaid services. As a result, the majority of dually eligible beneficiaries in D-SNPs still have two separate insurance cards with two different sets of benefits for Medicare and Medicaid services. The typical D-SNP is not at-risk for Medicaid spending or accountable for Medicaid outcomes. This type of arrangement is not true financial and clinical integration. A minority of state Medicaid programs have managed to overcome this issue by allowing the D-SNP to cover Medicaid services.⁹ Alternatively, a single managed care company can operate both a D-SNP and a Medicaid plan, which would allow some coordination across the two products.⁹ Unfortunately, these arrangements are still the exception rather than the rule.

Moving forward, I would encourage action in four areas on the part of your Committee. First, all D-SNPs should be both clinically and financially integrated with Medicaid. Otherwise, it is hard to make a case for this model over Medicare Advantage. Second, SNPs must show that they offer higher quality to beneficiaries to justify their existence. As noted above, the C-SNPs have shown relatively lower quality as compared with other models. Third, Medicare has historically underpaid for full dually eligible individuals in Medicare Advantage. This underpayment issue has been linked to low enrollment in the recent CMS Financial Alignment Initiative demonstration for duals.¹⁰ CMS recently adjusted payments upward for Duals to address this issue but continued oversight is needed to ensure that payments to SNPs are adequate to encourage high-quality care for the sickest, frailest Medicare beneficiaries. Finally, outside of an early CMS evaluation,¹¹ there has not been a recent major government-commissioned study of the SNPs. If we are going to continue to put public dollars into this program, we need a more rigorous and nuanced understanding of which SNP models work for which Medicare beneficiaries.

In summary, the theory behind financial and clinical integration of services for those frailest, most vulnerable beneficiaries is compelling. In practice however, we have not achieved meaningful integration in the majority of SNPs to date. Reforms that encourage true integration will help ensure high-value care for our frailest Medicare beneficiaries.

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Chairman TIBERI. Thank you. And last but not least, the gentleman from up north, as you would say in Ohio, Dr. Fendrick, you are recognized for 5 minutes.

STATEMENT OF A. MARK FENDRICK, MD, EXECUTIVE DIRECTOR, UNIVERSITY OF MICHIGAN CENTER FOR VALUE-BASED INSURANCE DESIGN, ANN ARBOR, MI

Dr. FENDRICK. Good afternoon, and thank you Chairman Tiberi, Ranking Member Levin, and Members of the Subcommittee. I am Mark Fendrick, a practicing primary care physician and a professor at the University of Michigan. Go Blue.

Mr. Chairman, I applaud you for holding this hearing because access to quality healthcare and containing Medicare costs are among the most pressing issues for our national well-being and economic security.

Moving Medicare Advantage from volume driven to a value-based program requires a change in both how we pay for care and how we engage consumers to seek care. Yet before today's hearing little attention has been directed to how we can alter beneficiary behavior to make MA more effective and efficient.

Today I urge you to support the bipartisan effort to allow MA plans across the country to incorporate value-based insurance design to help members become better healthcare consumers.

I could tell you with great confidence that my Medicare patients could care less how much the Federal Government spends on healthcare. But they do care deeply about the amount they have to pay out of pocket to get the care they need.

With rare exception, MA plans implement cost sharing in a one-size-fits-all way and each beneficiary is charged the same amount for every doctor visit, every diagnostic test and prescription drug. People ask me all the time whether the amount of cost sharing faced by MA members is too high or too low.

The answer, as every clinician knows, is it depends. But asking MA members to pay more for all services despite clear differences in clinical value results in decreases in the use of essential care, the care I beg my patients to do. And this cost-related nonadherence negatively impacts our most vulnerable patient populations. So I see this blunt one-size-fits-all approach as penny wise and pound foolish.

Does it make sense to you, Mr. Chairman, that my MA patients pay the same copayment to see a cardiologist after a heart attack as to see a dermatologist for mild acne or pay the same prescription drug copayment for a life-saving drug that treats diabetes, cancer, or depression as one that makes toenail fungus go away? Realizing that MA beneficiaries use too little high-value care and too much low-value care, I endorse a clinically nuanced cost-sharing approach as a potential solution.

Clinically nuanced value-based insurance designs set consumer cost-sharing levels to encourage the use of high-value services and providers and discourage the use of low-value care.

For the record, I support high cost-sharing levels but only for those services that do not make MA beneficiaries any healthier. Led by the private sector, V-BID is implemented by hundreds of public and private employers, several States, and will soon be in-

corporated into the TRICARE program. The integration of V-BID into MA has garnered broad multi-stakeholder and rare bipartisan support.

I would like to acknowledge Subcommittee Members Diane Black and Earl Blumenauer whose bipartisan leadership on this issue led to the 2015 announcement of the MA V-BID model test, a 5-year program that allows designated plans now in seven States to reduce cost sharing for specific services and providers, but only for those beneficiaries with specified chronic conditions.

In January of this year, nine MA plans successfully launched disease-specific programs combined with enhanced benefits to help people manage their chronic diseases. Responding to interest from MA plans in other States, CMS added three more States to the demo starting next year. So due to the V-BID success in the private sector, the TRICARE pilot, and nationwide interest in the MA V-BID model test, bicameral, bipartisan legislation has recently been introduced to allow MA plans in all 50 States the flexibility to allow MA plans to set beneficiary cost-sharing levels on clinical value, not price of medical services.

It is my hope that the Subcommittee supports the national expansion of V-BID and MA, which when coupled with other promising integrated models like the PACE program discussed today, could result in a healthier Medicare population, which motivates me as a physician, and more efficient Federal expenditures, thus serving the best interests of American taxpayers and future beneficiaries.

So it is my great pleasure to support the Medicare program, and I am happy to work with the Subcommittee further and look forward to hearing your comments and answering your questions. Thank you.

[The prepared statement of Dr. Fendrick follows:]



**UNITED STATES HOUSE OF REPRESENTATIVES WAYS AND MEANS HEALTH SUBCOMMITTEE
VALUE-BASED INSURANCE DESIGN IN THE MEDICARE ADVANTAGE PROGRAM**

Testimony of: A. Mark Fendrick, MD
Professor of Internal Medicine and Health Management & Policy
Director, Center for Value-Based Insurance Design
University of Michigan
www.vbidcenter.org
June 7, 2017

Good afternoon and thank you, Chairman Tiberi, Ranking Member Levin, and Members of the Subcommittee. I am Mark Fendrick, Professor of Internal Medicine and Health Management & Policy at the University of Michigan. I am addressing you today, not as a representative of the University, but as a practicing primary care physician, a medical educator, and a public health professional. I have devoted nearly three decades to studying the United States health care delivery system, and I founded the University's Center for Value-Based Insurance Design [www.vbidcenter.org] in 2005 to develop, implement and evaluate innovative payment initiatives and health insurance designs intended to improve quality of care, enhance the patient experience, and ensure efficient expenditure of health care dollars.

Mr. Chairman, I applaud you for holding this hearing on "Promoting Integrated and Coordinated Care for Medicare Beneficiaries." The provision of patient-centered, high quality health care for our most vulnerable Americans and the containment of health care cost growth are among the most pressing issues for our national well-being and economic security. I strongly concur with your statement that Medicare expenditures should not only serve the best interests of current Medicare members, but must also serve the best interests of American taxpayers and future beneficiaries.

With 18.5M enrollees in 2017 and growing, Medicare Advantage (MA) is at the forefront of developing innovative programs – some of which will be addressed today – to prevent, detect, and treat vulnerable seniors and people living with disabilities, especially those with complex chronic conditions. I will focus my testimony on the importance of providing MA plans increased flexibility to use value-based insurance design (V-BID) principles to create a benefit package that encourages MA members to become smarter health care consumers. V-BID plans work synergistically with the other integrated and coordinated care models discussed today.

There is strong bipartisan agreement that the U.S. spends far more per capita on health care than any other country, yet lags behind other nations that spend substantially less on key health quality and population health measures. Since

there is already enough money in the system, patient-centered outcomes can be improved if we reallocate our health care dollars to clinical services for which there is clear evidence for improving health. I believe that the primary goal of the Medicare program is to improve the health of its members, not to save money. Thus, the focus of our discussions should change from *how much* we spend to *how well* we spend our limited health care dollars.

FROM A VOLUME-DRIVEN TO VALUE-BASED SYSTEM

Moving from a volume-driven to value-based delivery system requires a change in both how we pay for care (supply-side initiatives) and how we engage consumers to seek care (demand-side initiatives). Other testimonies today and at earlier Subcommittee hearings have focused on the critical importance of reforming care delivery and payment policies. These are important and worthy conversations. Prior to this hearing, *little attention has been directed to how we can alter beneficiary behavior to bring about a more effective and efficient Medicare program.* Today, I propose that the goals of better health and cost containment are more likely to be achieved if MA plans were provided the flexibility to implement **benefit designs that promote personal responsibility and improve member decision-making.** I commend the Subcommittee for exploring this matter.

ROLE OF MEDICARE BENEFICIARY COST-SHARING

Chairman Tiberi, in the announcement for this hearing, you called for a review of programs designed to deliver integrated and coordinated care for our most vulnerable seniors and people living with disabilities; the potential clinical and financial impacts of these programs are staggering. Of the 57 million people covered by Medicare in 2016; 36% report Functional Impairment (1+ ADL Limitations); 34% Cognitive/Mental Impairment; 30% 5+ Chronic Conditions; and 27% Fair/Poor Health. I have dedicated my career to ensure that at-risk Medicare beneficiaries get the care they need – at a price they can afford – in a fiscally responsible way.

Over the past few decades, public and private payers – including Medicare – have implemented multiple managerial tools to constrain health care cost growth with varying levels of success. The most common approach to impact consumer behavior is cost shifting: requiring beneficiaries to pay more in the form of increased premiums and increased cost-sharing for clinician visits, diagnostic tests, and prescription drugs. I can tell you with great confidence that **the typical Medicare beneficiary does not worry about the total amount that the U.S. spends on health care, but they do care deeply about what it costs them.** In 2016, more than 25% of Medicare beneficiaries spent 20% or more of their income on out-of-pocket (OOP) health care costs.

A significantly growing share of out-of-pocket spending is devoted to high cost medications, many of which have profound positive impact on beneficiary

health. Most Medicare beneficiaries taking a specialty drug will spend more than \$2,000 over the course of one year. Out-of-pocket costs for common, life-changing treatments for rheumatoid arthritis, Hepatitis C, and multiple myeloma frequently surpass \$4,500, \$6,500, and \$11,500 respectively. To meet the growing burden, charitable foundations collectively provide Medicare members hundreds of millions of dollars each year. As health care costs escalate, most suggest that member OOP will continue to grow.

DANGERS OF A BLUNT APPROACH TO BENEFICIARY COST-SHARING – THE IMPORTANCE OF “CLINICAL NUANCE”

With some notable exceptions, MA plans implement cost-sharing in a ‘one-size-fits-all’ way, in that beneficiaries are charged the same amount for every doctor visit, diagnostic test, and prescription drug [within a specified formulary tier]. As Medicare beneficiaries are required to pay more to visit their clinicians and fill their prescriptions, a growing body of evidence demonstrates that increases in patient cost-sharing lead to decreases in the use of both non-essential and essential care across the entire continuum of clinical care. A systematic review of the published literature revealed that the rise in cost-sharing for Medicare beneficiaries resulted in lower adherence with recommended preventive screenings and prescription drugs to manage common chronic conditions, as well as reduced outpatient visits, leading to a rise in hospitalizations. Cost-related non-adherence (CRN) was shown to negatively impact the most vulnerable patient populations, especially those with lower socioeconomic status and multiple chronic conditions.

A noteworthy example is a *New England Journal of Medicine* study that examined the effects of increases in copayments for doctor visits in Medicare Advantage plans [Trivedi A. *N Engl J Med*. 2010;362(4):320-8]. As expected, individuals who were charged more to see their physician went less often; however, these patients were hospitalized more frequently, and their total medical costs increased. While this blunt approach may reduce expenditures in the short-term, higher rates of noncompliance may lead to inferior health outcomes and higher overall costs in certain clinical circumstances. This seemingly counterintuitive effect simply demonstrates that the age-old aphorism “penny wise and pound foolish” applies to health care. The lack of robust consumer incentives to improve their own health, coupled with illness burden, intense medication needs, and high out-of-pocket costs, often lead to undesired clinical and financial outcomes.

Since the decreased use of essential clinical services leads to reductions in quality, suboptimal patient-centered outcomes, and – in certain instances – increases in aggregate health care spending, solutions to this growing problem are urgently needed. **To efficiently reallocate medical spending and optimize population health, the basic tenets of clinical nuance must be considered. These tenets recognize that: 1) medical services differ in the benefit provided;**

and 2) the clinical benefit derived from a specific service depends on the patient using it, as well as when, where, and by whom the service is provided.

Does it make sense to you, Mr. Chairman, that my Medicare patients pay the same copayment to see a cardiologist after a heart attack, as they do to see a dermatologist for mild acne? Or that their copayment is the same for a drug that could save their life from cancer, diabetes, or heart disease, as it is for toenail fungus treatment? On the generic drug tier available to most Americans, there are drugs so valuable that I have often reached into my own pocket to help patients fill these prescriptions; while for the same price, there are also drugs of such dubious safety and efficacy, I honestly would not give them to my dog. In the specialty drug tier, Medicare patients pay the same co-insurance for a 'precision' drug targeted to a specific genetic marker that cures cancer 90% of the time, as they do for a conventional therapy that rarely cures a single case.

Our current 'one-size-fits-all' system lacks clinical nuance, and frankly, to me, makes no sense. MA beneficiaries use too little high-value care and too much low-value care. We need benefit designs and other programs that support consumers in obtaining evidence-based services such as diabetic retinal exams and life-saving drugs through lower cost-sharing (when clinically indicated) and discourage individuals through higher cost-sharing from using dangerous or low-value services such as those identified by professional medical societies in the *Choosing Wisely* initiative. **By incorporating greater clinical nuance into benefit design, payers, purchasers, beneficiaries and taxpayers can attain more health for every dollar spent.**

VALUE-BASED INSURANCE DESIGN [V-BID]

Over the past two decades, public and private payers have implemented clinically nuanced plans, referred to as Value-Based Insurance Design, or V-BID. The basic V-BID premise calls for reducing financial barriers to evidence-based services and high-performing providers and imposing disincentives to discourage use of low-value care. A V-BID approach to benefit design recognizes that different health services have different levels of value. It's common sense – when barriers to high-value treatments are reduced and access to low-value treatments is discouraged, these plans result in better health at any level of care expenditure.

Let me be clear, Mr. Chairman, I am not asserting that V-BID is a panacea to the challenges facing MA plans. But, if we are serious about "bending the health care cost curve" and improving health outcomes, we must change the incentives for consumers, as well as those for providers. **Cost containment through blunt changes to Medicare benefit design must not produce avoidable reductions in quality of care.**

Your Subcommittee is examining many of the bright spots in Medicare

Advantage aimed to better integrate and coordinate care. If these initiatives provide incentives to clinicians to recommend the right care, it is of equal importance that incentives for the patients are aligned with these goals as well. As a physician practicing in an alternative payment model, it is incomprehensible to realize that my patients' coverage often does not offer easy access for those exact services for which I am benchmarked. Does it make sense that I am offered a financial bonus to get my patients' diabetes under control when the benefit design makes it prohibitively expensive to fill their insulin prescription or provide the copayment for their eye examination?

I'm pleased to tell you that the intuitiveness of clinically nuanced design is driving momentum at a rapid pace, and we are truly at a "tipping point" in its adoption. Hundreds of public purchasers, private self-insured employers, non-profits, and insurance plans have designed and tested value-based programs. Just a few examples include the State Employee Plans in Oregon, Connecticut, and Kentucky, each of which provide incentives for individuals with chronic diseases to seek the right care, at the right time, from the right provider. In January 2018, the TRICARE program will launch a V-BID demonstration to improve health outcomes and enhance the experience of care for U.S. Armed Forces military personnel, military retirees, and their dependents.

INFUSING 'CLINICAL NUANCE' INTO MEDICARE ADVANTAGE

In theory, Medicare Advantage can implement innovative programs designed to improve value by applying techniques successfully implemented in the commercial health insurance market. In reality, the tools available to Medicare Advantage are limited, and include network formation, performance bonuses, and utilization management programs. The use of these blunt instruments often does not align economic incentives with clinical value, thereby hindering a plan's ability to design benefits to promote quality and efficiency. This lack of flexibility is problematic, in that it fails to recognize the well-accepted notion that health care services differ in the clinical benefit achieved. Moreover, it does not align with the exciting advances in personalized or 'precision' medicine that are tailored to specific clinical characteristics. Additional flexibility in benefit design would allow Medicare Advantage plans to achieve greater efficiency and encourage personal responsibility among members.

There are two major restrictions within the Medicare Advantage program that prevent clinical nuance and the promotion of high-value services and providers: (1) a lack of flexibility to steer patients to high-value providers, and (2) a rigid, outdated benefit design. The standards for provider networks and non-discriminatory benefit designs were established in an effort to protect consumers from unfavorable practices such as predatory risk steering. While some of these provisions successfully improve consumer protection, they also

severely limit innovation within the Medicare Advantage program and perpetuate a ‘one-size-fits-all’ approach to care delivery. Since these consumer protection standards prevent seniors from receiving the highest possible clinical benefits of care, they may be construed as undermining their original intent.

I. FLEXIBILITY IN IMPOSING DIFFERENTIAL COST-SHARING FOR USE OF DIFFERENT PROVIDERS OR SETTINGS

Since the value of a clinical service may depend on the specific provider or the site of care delivery, **Medicare Advantage plans should have the flexibility to vary cost-sharing for a particular outpatient service in accordance with who provides the service and /or where the service is delivered.** The Commonwealth Fund Commission on a High Performance Health System estimated that \$189 billion in savings would accrue to Medicare over 10 years if we were to “develop a value-based design that encourages beneficiaries to obtain care from high-performing care systems.” This flexibility is increasingly feasible, as quality metrics and risk-adjustment tools become better able to identify high-performing health care providers and/or care settings that consistently deliver superior quality. For example, a Medicare Advantage plan might wish to impose a \$50 copayment for an out-of-network office visit, a \$25 copayment for an in-network office visit, and a \$0 copayment for an in-network office visit that takes place at a recognized patient-centered medical home (PCMH), that has demonstrated better performance on key quality measures. Existing rules prohibit this level of variance in beneficiary cost-sharing, as Medicare Advantage plans are allowed to create a provider network, but are limited in how they vary copays *within* that network. Strict standardization in the cost-sharing structures within a network severely hinders the ability of Medicare Advantage plans to promote high quality care and take steps to reduce waste and inefficiency.

The provider network requirements also create challenges for care coordination among providers. The inability to use incentives to encourage beneficiaries to access care across a specified provider group hinders the ability for practitioners to track progress, encourage proper follow-up, and prevent the need for costly services due to lack of medical adherence. This is particularly important as we seek a return from a multi-billion dollar investment in health information technology. While the long-term intent of electronic medical records is to seamlessly share data across all providers, currently the most common use is among providers in a designated group.

Improving provider choice is an essential tool that will allow plans to incorporate clinical nuance, enhance consumer engagement, and drive higher quality of care in Medicare Advantage products. **Network adequacy standards must allow issuers to create multi-tier cost-sharing structures by encouraging and requiring different tiers of co-pays for services and providers that have proven high- and low-value outcomes.** Many stakeholders recognize the merits of

253 permitting plans greater flexibility to incentivize beneficiaries to select high
 254 performing providers; the Medicare Payment Advisory Committee submitted
 255 these recommendations in several recent Reports to Congress.

256 II. FLEXIBILITY IN IMPOSING DIFFERENTIAL COST-SHARING FOR USE OF DIFFERENT SERVICES

257 To date, most clinically nuanced designs have focused on lowering patient
 258 out-of-pocket costs for high-value services. These are the services I beg my
 259 patients to do – for which there is no question of their clinical value – such as
 260 immunizations, preventive screenings, and critical medications and treatments
 261 for individuals with chronic diseases such as asthma, diabetes and mental illness
 262 (e.g. as recommended by National Committee for Quality Assurance, National
 263 Quality Forum, professional society guidelines). Despite unequivocal evidence
 264 of clinical benefit, there is substantial underutilization of these high-value
 265 services in the MA program across the spectrum of care. Multiple
 266 peer-reviewed studies show that when patient barriers are reduced, compliance
 267 goes up, and, depending on the intervention or service, total costs go down.

268 Yet, from the payer's perspective, the cost of incentive-only based V-BID
 269 programs depends on whether the added spending on high-value services is
 270 offset by a decrease in adverse events, such as hospitalizations and visits to the
 271 emergency department. While these high-value services are cost-effective and
 272 improve quality, many are not cost saving – particularly in the short term.
 273 However, research suggests that non-medical economic effects – such as impact
 274 on caregiver burden – can substantially impact the financial results of V-BID
 275 programs.

276 While significant cost-savings are unlikely with incentive-only programs in the
 277 short term, **a V-BID program that combines reductions in cost-sharing for**
 278 **high-value services and increases in cost-sharing for low-value services can**
 279 **both improve quality and achieve net cost savings.** Removing
 280 harmful/unnecessary care from the system is essential to reducing costs, while
 281 creating an opportunity to improve quality and patient safety. Evidence
 282 suggests significant opportunities exist to save money without sacrificing
 283 high-quality care. Though less common, some V-BID programs are designed to
 284 discourage use of low-value services and poorly performing providers.
 285 Low-value services result in either harm or no net benefit, such as services
 286 labeled with a D rating by the U.S. Preventive Services Task Force. **Many**
 287 **services that are identified as high quality in certain clinical scenarios are**
 288 **considered low-value when used in other patient populations, clinical**
 289 **diagnoses, or delivery settings.** For example, cardiac catheterization, imaging
 290 for back pain, and colonoscopy can each be classified as a high- or low-value
 291 service depending on the clinical characteristics of the person, when in the
 292 course of the disease it is provided, and the where it is delivered.

293 Fortunately, there is a growing movement to both identify and discourage the

use of low-value services. The ABIM Foundation, in association with Consumers Union, has launched *Choosing Wisely*, an initiative where medical specialty societies identify commonly used tests or procedures whose necessity should be questioned and discussed. Thus far, more than 40 clinical specialty societies have identified at least five low-value services within their respective fields. Immediate and substantial cost savings are achievable through the reduction of low-value care. Thus, programs that include both carrots and sticks may be particularly desirable in the setting of budget shortfalls.

III. FLEXIBILITY IN IMPOSING DIFFERENTIAL COST-SHARING FOR CERTAIN SERVICES FOR SPECIFIC ENROLLEES

Since a critical aspect of clinical nuance is that the value of a medical service depends on the person receiving it, we recommend that Medicare Advantage plans be granted the flexibility to impose differential cost-sharing for specific groups of enrollees. **The flexibility to target enrollee cost-sharing based on clinical information (e.g., diagnosis, clinical risk factors, etc.) is a crucial element to the safe and efficient allocation of Medicare Advantage expenditures.** Under such a scenario, a plan may choose to exempt certain enrollees from cost-sharing for a specific service on the basis of a specific clinical indicator, while imposing cost-sharing on other enrollees for which the same service is not clinically indicated. Under such a clinically nuanced approach, plans can recognize that many outpatient services are of particularly high-value for beneficiaries with conditions such as diabetes, hypertension, asthma, and mental illness, while of low-value to others. For example, annual retinal eye examinations are recommended in evidence-based guidelines for enrollees with diabetes, but not recommended for those without the diagnosis. Without easy access to high-value secondary preventive services, previously diagnosed individuals may be at greater risk for poor health outcomes and avoidable, expensive, acute-care utilizations. Conversely, keeping cost-sharing low for these services for all enrollees, regardless of clinical indicators, can result in overuse or misuse of services leading to wasteful spending and potential for harm.

Currently, Medicare Advantage plans – with the exception of those participating in the CMS MA V-BID model test (discussed in detail below) – are constrained by non-discrimination rules that prohibit plans from tailoring benefits to particular subgroups of patients, for which a given service may be of particularly high-value. If MA plans were to encourage the use of a certain service by lowering copays, they must lower copays for everyone in the plan, even though clinical appropriateness may vary. In order to allow plans to incorporate the principles of clinical nuance in their MA products, the standards regarding targeting intervention by clinical circumstance should be updated.

Although the ‘one-size-fits-all’ approach to Medicare copayments dates back to its inception in the 1960s, support for the incorporation of V-BID principles into

Medicare Advantage (MA) plans has garnered longstanding multi-stakeholder and bipartisan political support. In 2009, Senators Hutchison and Stabenow introduced a bipartisan bill, S.1040: *Seniors' Medication Copayment Reduction Act of 2009*, to allow a demonstration of V-BID in the Medicare Advantage program. The *Seniors' Medication Copayment Reduction Act* (2009, S. 1040), the *Better Care, Lower Cost Act of 2014* (S. 1932), and *The Strengthening Medicare Advantage through Innovation and Transparency for Seniors Act of 2015* (H.R. 2570) all proposed incorporating V-BID principles into MA.

To assess the fiscal impact of the first year of MA V-BID programs, an actuarial analysis from the patient, plan, and societal perspectives was undertaken for diabetes mellitus (DM), chronic obstructive pulmonary disease (COPD), and congestive heart failure (CHF). After the first year, V-BID programs reduced consumer out-of-pocket costs in all three conditions. Plan costs increased slightly for DM and COPD, and the plan realized cost savings for CHF. From the societal perspective, the DM program was close to cost neutral; net societal savings resulted in the COPD and CHF programs.

CMS MEDICARE ADVANTAGE V-BID MODEL TEST

In the fall of 2015, the Centers for Medicare and Medicaid Services (CMS) announced the Medicare Advantage V-BID model test to assess the utility of structuring consumer cost-sharing and health plan elements to encourage the use of high-value clinical services and providers. MA plans in Arizona, Indiana, Iowa, Massachusetts, Oregon, Pennsylvania, and Tennessee were eligible to implement programs for seven CMS specified chronic conditions. Changes to benefit design made through this model may only reduce cost-sharing and/or offer additional services to targeted enrollees. Under no circumstances can targeted enrollees receive fewer benefits or have to pay higher cost-sharing than other enrollees as a result of the model. Four approaches to benefit design are permitted in the model:

1. Reduced Cost-Sharing for High-Value Services

Plans can choose to reduce or eliminate cost-sharing for items or services, including covered Part D drugs, that they have identified as high-value for a given target population. Participating plans have flexibility to choose which items or services are eligible for cost-sharing reductions; however, these services must be clearly identified and defined in advance, and cost-sharing reductions must be available to all enrollees within the target population. Examples of interventions within this category include eliminating co-pays for eye exams for members with diabetes and eliminating co-pays for angiotensin converting enzyme inhibitors for enrollees who have previously experienced an acute myocardial infarction.

2. Reduced Cost-Sharing for High-Value Providers

Plans can choose to reduce or eliminate cost-sharing when providers that the plan has identified as high-value treat targeted enrollees. Plans may identify high-value

providers based on their quality and not solely based on cost, across all Medicare provider types, including physicians/practices, hospitals, skilled-nursing facilities, home health agencies, ambulatory surgical centers, etc. Examples of interventions within this category include reducing cost-sharing for members with diabetes who see a physician who has historically achieved strong results in controlling patients' HbA1c levels and eliminating cost-sharing for heart disease patients who elect to receive non-emergency surgeries at high-performing cardiac centers.

3. Reduced Cost-Sharing for Enrollees Participating in Disease Management or Related Programs

Participating plans can reduce cost-sharing for an item or service, including covered Part D drugs, for enrollees who choose to participate in a plan-sponsored disease management or similar program. This could include an enhanced disease management program, offered by the plan as a supplemental benefit, or it could refer to specific activities that are offered or recommended as part of a plan's basic care coordination activities. Plans using this approach can condition enrollee eligibility for cost-sharing reductions on meeting certain participation milestones. For instance, a plan may require that enrollees meet with a case manager at regular intervals in order to qualify. However, plans cannot make cost-sharing reductions conditional on achieving any specific clinical goals (e.g., a plan cannot set cost-sharing reductions on enrollees achieving certain thresholds in HbA1c levels). Examples of interventions within this category include elimination of primary care co-pays for diabetes patients who meet regularly with a case manager and reduction of drug co-pays for patients with heart disease who regularly monitor and report their blood pressure.

4. Coverage of Additional Supplemental Benefits

Under this approach, participating plans can make coverage for specific supplemental benefits available only to targeted populations. Such benefits may include any service currently permitted under existing Medicare Advantage rules for supplemental benefits.

Nine MA plans started the model test in January 2017. Aetna's "Healthy Heart Partnership," Geisinger's "COPD Support" and UPMC's "Spark Your Health" are excellent examples of how enhanced benefits for members with a complex chronic condition can be coupled with care management programs to better engage patients and improve clinical outcomes. Responding to interest from MA plans in states not included in the demonstration, CMS announced that the model will expand to 10 (from 7) states and add two clinical conditions for 2018.

BIPARTISAN SUPPORT TO EXPAND MA V-BID MODEL TO ALL 50 STATES

Due to V-BID's success in the public and private sector, the TRICARE V-BID pilot, and early enthusiasm for the MA V-BID demonstration, the U.S. Senate Finance Committee introduced S.870: *Creating High-Quality Results and Outcomes Necessary to Improve Chronic Care Act* (CHRONIC) of 2017, a bipartisan bill that specifically calls for the expansion of the V-BID MA demonstration to all 50 states. Recently, Representative Diane Black (R-TN), along with co-sponsors Earl Blumenauer (D-OR), Cathy McMorris Rodgers (R-WA), and Debbie Dingell (D-MI), introduced the *V-BID for Better Care Act of 2017* (H.R. 1995), which seeks to provide national testing of the Medicare Advantage V-BID Model. **The national implementation of clinically nuanced benefit designs presents an enormous opportunity for the Medicare Advantage program.**

Although there is urgency to bend the health care cost curve, cost containment efforts should not produce avoidable reductions in quality of care, particularly for the most vulnerable among us. It is my hope that as your Subcommittee considers changes to the Medicare Advantage program, you will take the important step of providing MA plans in all 50 states the flexibility to set cost-sharing levels based on whether an intervention is high-value or low-value. Encouraging the use of high-value services and providers, and discouraging those with low value, will decrease cost-related non-adherence, reduce health care disparities, and improve the efficiency of health care spending without compromising quality. This approach – working in concert with other exciting integrated care models discussed today – would result in a healthier population, and contain the growth of Medicare expenditures, thus serving the best interests of American taxpayers and future beneficiaries.

Thank you.



Chairman TIBERI. Thank you, Doc. Not bad for a Michigan guy.
Dr. FENDRICK. Thank you.

Chairman TIBERI. Ms. Wilson, just a thought on the PACE program.

I think we all agree that most of us as we age and become elderly would prefer to remain in our homes. Ensuring that Medicare beneficiaries have the option to safely stay in their homes along with the right support system is obviously important, but it often requires a dedicated caregiver who can help with household needs or transportation or meals.

Caring for that elderly family or friend can be awfully difficult at times and can take a toll both mentally and physically and sometimes actually financially.

Can you expand on that, comment on that, and give us your thoughts?

Ms. WILSON. One of the challenges is to keep the person, the participant, the patient at home because that is where they want to be, but it is challenging.

Ninety-five percent of all PACE participants, however, do live at home, and that is across the country. The way that happens is because the interdisciplinary team meets on a daily basis and the needs of that person at home are just as important as the medical conditions that are treated once they come into the clinic. So taking care of things at home, such as meals, housecleaning, grab rails in the bathroom so people don't fall, all of those things, are very important.

The social components of healthcare are just as important to save dollars on the healthcare side and to make keeping somebody at home efficient and effective is the key to PACE.

Chairman TIBERI. Mr. Grabowski and Ms. Jacobson, if you can comment on this, you specifically spent quite a bit of time in your testimony on the dual eligibles.

Dual eligibles are auto assigned Medicare prescription drug plans in several States, including my own State of Ohio, and they are allowed to auto enroll dual eligible beneficiaries with opt-out parameters in the D-SNPs specifically. Can auto assignment lead to higher beneficiary enrollment in your opinion and can auto assignment be used as an incentive maybe to fully integrate their benefits in the D-SNPs?

Mr. GRABOWSKI. Yes, maybe I will start. There was actually some early experience with auto enrollment or passive enrollment in the SNPs.

Several States actually had their beneficiaries, Texas, would be an example, Arizona, Minnesota, about 50,000 beneficiaries were automatically or passively enrolled into the D-SNPs. So there was some early experience that it actually worked. I think it can increase enrollment numbers. I would be wary of saying it is going to get everyone enrolled, but it will get a broader selection of individuals in, so it gets around some of the risk selection issues that many of us have been so concerned about with plans cherry-picking or attracting certain types of beneficiaries.

I would point, however, to the work we have done on the financial alignment initiative, the CMS demonstrations for the duals. We looked at eight States, and all of those eight States used pas-

sive enrollment or auto enrollment, and it turned out only about 25 percent of eligible duals stuck. So that means that 75 percent opted out. You will be happy to hear, Mr. Chairman, the State that did the best was Ohio actually.

Chairman TIBERI. Wow.

Mr. GRABOWSKI. Yes. About two-thirds of beneficiaries remained in the dual demo. Ohio did a very clever thing by first enrolling individuals passively into Medicaid in a first stage, and then doing Medicare in a second stage.

On the other end of the spectrum, New York had the lowest enrollment at 5 percent. There, they coupled their enrollment process with counseling and required each new beneficiary to actually go through counseling. That turned out to be a mistake in that a lot of individuals didn't want to undertake the counseling, and hence, opted out of the program.

Chairman TIBERI. Okay.

Mr. GRABOWSKI. So I guess passive enrollment will work to bring enrollees in. It will bring in a more diverse group of enrollees. I think the challenge is that it won't get everyone, and I do think how you design the passive enrollment, the Ohio/New York difference, really matters.

Thank you.

Chairman TIBERI. Ms. Jacobson.

Ms. JACOBSON. I agree. The financial alignment models do provide a precedent for this. You do need to really consider, though, that more than half of dual eligibles have some sort of mental impairment or cognitive impairment. So it is really important to consider not only that they have a method of opting out, but also, that they know about it and that they are aware of it.

And this is very difficult when you are talking about a population with schizophrenia, Alzheimer's disease and other mental illnesses to make sure that they really understand they have another option that they can go to.

Chairman TIBERI. Great point. Doc, you mentioned the CMS V-BID demonstration, and in your opinion, if you could expand on it, the demonstration is set up in a way that allows Medicare Advantage plans the necessary flexibility for them to reach the full benefit of the V-BIDs?

Dr. FENDRICK. So that is a great question, and it is important to point out that, as mentioned in Dr. Jacobson's remarks, when Medicare was introduced in 1965 one of the foundations was this nondiscrimination clause that every American in Medicare have the same benefit design, and it, as all clinicians, and like Representative Black, know, medicine is unbelievably personalized and moving rapidly in that direction down to the level of the gene.

So we have argued that people should be treated differently and given access to different care, most notably an eye exam, which should be more easily accessed by someone who has diabetes than someone who doesn't. And it was quite a task, and I thank this Subcommittee for the leadership to have this waiver be the first ever to allow a Medicare recipient with a specific condition to have a different benefit design than someone else, allowing precision medicine to be aligned with benefit design. So important step forward.

Three of the States that are expanding to next year are represented on this Committee, and I think that there is movement afoot by CMMI to allow greater flexibility and uptake of these programs, most notably one is that the conditions are designated by CMMI. I think the plan should have a little bit more flexibility to decide which population should be available to have greater access to certain services and providers.

I think that we should allow the plans to expand the services that they can reduce cost sharing for across the entire spectrum of care, and I think given that the fiscal responsibility that we must attend to with any changes in Medicare is to say we can't always spend more, we often have to cut back.

And given that most of the blunt instruments get people to use less of all care, I think it is important now for Medicare to walk very slowly and carefully into the area of reducing the hundreds of billions of dollars of Medicare expenditures that don't make one beneficiary any healthier.

There is a new initiative called the Choosing Wisely program, which has launched over 40 clinical specialty societies, naming specific services that maybe we are doing too often and spending too much money on. So broader spectrum of services, more flexibility on the specific conditions and to start to pay attention to the fact that while the best part of the demo is making high-value services more accessible, to be fiscally responsible we have to start thinking about clinically driven reduction of low-value care.

Chairman TIBERI. Thank you. With that, Mr. Levin is recognized.

Mr. LEVIN. Thank you, and, again, welcome. Just a word on integration. As I look about us, the four of us Democrats on the Committee at the time of ACA were in the vanguard of those who sought to have more integration, more bundling, all kinds of concepts. And some of that was built into ACA in part I think because of the efforts of some of us here on the Committee.

Let me just say a word about the interaction between Medicare and Medicaid because when we have been debating healthcare reform there has been very little attention to that.

So I would like us, I guess, Ms. Jacobson, you referred to it and others might comment, just how important it is and the potential impact of reduction of Medicaid on dual eligibles and others who are in like positions.

If you could, it can be complicated, but I think it can also be stated rather clearly. Why don't you try? What is at stake when we talk about dramatic decreases in Medicaid as in the bill that passed here and then the President's proposal for an additional, what, \$600 billion?

Ms. JACOBSON. Okay. Like you said, this is a very complicated issue and could have a wide range of effects. One thing that a per capita cap like that would do is it does lock in historic spending.

So, for example, while it would adjust for the changes in the number of people who may be on the program, it would not necessarily adjust for the services that a State may want to provide to the people in the program. So, for example, if it would like to shift more people into community-based services, which seniors prefer, it may not have the financial flexibility to do so without cut-

ting back on other benefits. It would be more of a tradeoff financially for a lot of States because the mix of services they provide to some extent would be constrained.

It would affect, most importantly to note, that one in five people on Medicare who also receive benefits from Medicaid most of whom received cost sharing and full Medicaid benefits, as well. So this would affect a significant share of people on Medicare.

Mr. LEVIN. Does anybody else want to comment on that? Mr. Grabowski.

Mr. GRABOWSKI. Sure. I assume we will talk a lot today on the adequacy of payments on the Medicare side of the SNPs. If we are not contributing enough on the Medicaid side, if there are shortfalls there, that is also going to lead to access problems, quality of care problems, and a lot of my research has suggested when you underfund Medicaid that causes spillovers to Medicare.

So you underfund nursing home care or care in the home or the community, that leads to more Medicare-financed hospitalizations for dually eligible individuals. So to think about these programs as being in their own silos is a mistake.

For the dually eligible individuals, how we finance and deliver Medicaid services matters for Medicare spending and outcomes, and the opposite obviously is true, as well. How we pay for and deliver Medicare services matter for Medicaid outcomes and spending. They are linked, and so you can't think about them separately. So any kind of cut in Medicaid will have impacts for the Medicare program as well as for the dually eligibles.

Mr. LEVIN. Anybody else want to comment on that?

Ms. WILSON. Medicaid pays about 65 percent of a PACE participant's capitated rate, and so Medicaid is a very important piece. I think each State will have to look deep into their souls and decide how those Medicare dollars are going to be expensed into which populations because there are many populations other than seniors who receive Medicaid funds.

I think it is going to be a very difficult decision, and I think those of us who serve seniors will be faced with very difficult decisions. And I think we will have to be very creative because I don't see any of us wanting to cut back on any services for seniors going forward.

Mr. LEVIN. Thank you.

Chairman TIBERI. Thank you. Before I recognize Mr. Roskam I just want to remind Members that we do not have jurisdiction, though we would love to have jurisdiction in the Medicaid program, Mr. Walden and Dr. Burgess would not like that, so if we could kind of focus within our jurisdiction.

With respect to that, Mr. Roskam is recognized for 5 minutes.

Mr. ROSKAM. Thank you, Mr. Chairman. Admonition received. June is Alzheimer's and brain awareness month, and it is no surprise to anybody on this panel the devastating nature of this disease. It is the sixth leading killer in the United States, 5 million Americans are suffering from it, and some folks suggest that it is the most expensive disease in the United States that people are suffering with.

One of our colleagues, Representative Sánchez, and I have been working on legislation that would authorize a CMS demonstration

in terms of a general approach on this. So that is all to say there is a lot of interest in how all these things have an interaction with Alzheimer's in particular.

Dr. Jacobson, what is your insight or what is your perspective on how many Alzheimer's patients are enrolled in SNPs, and in your opinion what are the benefits that these plans have for Alzheimer's patients and their families based on your experience?

Ms. JACOBSON. We actually don't have the data on how many Alzheimer's patients are enrolled in SNPs. That is possibly something that we could look into and I could get back to you or your staff after this hearing.

Mr. ROSKAM. Okay. That would be helpful.

Ms. JACOBSON. Yes. So we really don't know to what extent what additional services and benefits are being provided to all SNP enrollees, including people who have Alzheimer's. So it is really difficult to say what they are actually receiving that is helping them in these SNPs.

Mr. ROSKAM. Anybody else have a perspective on that?

Ms. WILSON. In PACE, 50 percent of our population has some form of dementia or Alzheimer's disease, and it is a challenge. It is truly a challenge. So moving forward we need to deal with this. We are dealing with it very well in the PACE program right now. We are able to still keep those people at home. And as I mentioned before, some of them are living alone at home, but it is something that we are seeing as a future problem as the population grows.

Mr. ROSKAM. Okay.

Mr. GRABOWSKI. Although we can't give you the exact number, there are undoubtedly a number of individuals with dementia in the different SNP models. I can say there are very few chronic condition SNPs focused just on dementia.

The majority of the C-SNPs are focused on diabetes. I think just given the prevalence here we actually need to do better across the board in dementia care. I don't think a specialized model is really the way forward. I would prefer to see all Medicare Advantage plans get better at dementia care. Trying to build more specialized models I don't think is the best path forward just given the numbers you already cited.

Mr. ROSKAM. Okay. Dr. Fendrick.

Dr. FENDRICK. Briefly, just for the reasons that you seek, Mr. Roskam, I was very pleased to see that not only were three States added to the V-BID demo for 2018, but two conditions were added, as well, which dementia was one.

So we are very hopeful since many of the States represented on this Subcommittee are actually in those demo States, the seven original States, and Michigan, Alabama, and Texas all represented here would talk to their Medicare Advantage plans to encourage them to step away from diabetes, heart disease, COPD, the more common conditions now in the current demo and think outside the box and move to explore a V-BID MA dementia model that would, I think, lead to the increase in care that you are looking for.

Mr. ROSKAM. Okay. Thank you, all. Mr. Chairman, I yield back.

Chairman TIBERI. Ms. Sewell, you are recognized for 5 minutes.

Ms. SEWELL. Thank you, Mr. Chairman. Today we are talking a lot about saving costs and increasing value in the Medicare pro-

gram. The reality is that we are not going to save costs in the long run if we don't improve outcomes.

For our most vulnerable Medicare beneficiaries, especially our dual eligible, transportation barriers are often linked to poor outcomes.

My office gets calls from seniors in my district who face both transportation and financial barriers to accessing basic healthcare services. Whether you are an urban or rural resident, if you are disabled and elderly with limited income and no access to a car or public transportation, even a few blocks can be the difference between you going to the doctor or not.

My constituent Eva is 81 years old. She is dual eligible. In Selma, my hometown, Selma, Alabama. She is a diabetic, and when she has to go to the doctor, having no transportation, she really depends upon the neighborhood boys to drive her there.

When Miss Eva's Social Security check doesn't make ends meet, she can't afford to pay the neighborhood boys to take her to the doctor, so she misses many appointments. In addition to diabetes, Miss Eva has a disease that doesn't allow her to cut her own toenails, a more advanced stage of diabetes. And so, often many times she has to continue to have this very painful procedure done. She can't get it done at home because they are so afraid that something would go wrong with her diabetes, and so she can't walk often-times.

For diabetes, foot care cannot be ignored like that of Miss Eva. She often ends up at the emergency room having no transportation.

Mr. Chairman, stories like Miss Eva's are more common than they are rare. This is not sustainable for patients or for the system as a whole. As I have said before, we aren't going to reduce costs until we improve outcomes.

Had Miss Eva been enrolled in a plan that provided transportation services or had been educated on the resources available to her through non-emergency medical transportation, her emergency room visits would have been prevented.

As you mentioned, Ms. Wilson, PACE organizations provide care in the home and transportation services to providers in the community. PACE organizations expand and improve on other services available which are often inaccessible for frail and elderly populations like Miss Eva.

The PACE program, however, is a very small program in my home State of Alabama, and, in fact, only services 200 Alabamians and is not available in Selma, Alabama, so Miss Eva cannot take part in it.

My question is to you, Ms. Wilson: In your testimony you talked about a story about a lady enrolled in your PACE program that made me think of Miss Eva, and I know that in California you have access to a broader range of transportation than we do in Alabama.

And my question is, do you believe that there are areas around the country where the PACE program would not work or where the program has not been successful? Likewise, what are the greatest barriers to expansion of the PACE program or Special Needs Plans in rural communities like Selma?

Ms. WILSON. Thank you for that example. That is very touching.

Transportation is very definitely one of the greatest needs for our seniors because it isolates them. They can't get to the grocery store, they can't get to the laundromat, they can't get to the doctor. And emergency room visits are the response to that. So you are absolutely right. Transportation can be provided by PACE. Can PACE be provided in Selma? PACE can be provided anywhere.

Ms. SEWELL. So rural communities are not being managed, even though when you look at where your programs are, where the PACE programs are they are mostly in urban areas and not in rural communities.

Ms. WILSON. There are quite a few in rural communities. It started as a pilot project under CMS, and they have been very successful.

And most of those services are provided in the home with professionals going to the home because travel distances are a little bit longer than in urban areas, but still the services needed to be provided, and they are provided more often by community service providers rather than PACE employees doing it in the center itself.

So I would encourage you to encourage your State. Part of the problem with the difficulty in starting new programs is the cost and the timeframes to start new programs, and if we could all work with our State Representatives and also with the CMS representatives to help speed up the process, there would be many more PACE programs across the country.

Ms. SEWELL. Thank you very much. I yield back.

Chairman TIBERI. Thank you. Mr. Smith is recognized for 5 minutes.

Mr. SMITH. Thank you. Thank you to our witnesses here today, and certainly I appreciate the perspective.

My colleague just raised some concerns about rural areas and perhaps the flexibility. I know that flexibility in general has afforded a lot of Americans within Medicare Advantage some options, and I think that is helpful, but it certainly hasn't really provided as many options for what I would say are rural residents and then residents of very remote areas, and sometimes those services just are hard to come by, and whether it is Selma or whether it is range country in rural Nebraska, that there are some vast areas there that I hear, you know, from various seniors their concerns.

But I am just wondering if you would like to elaborate at all on what was already asked or what other innovative ideas you might have, Mr. Grabowski, or Dr. I guess it is, if you would care to elaborate?

Mr. GRABOWSKI. Yes. So I will start by saying Special Needs Plans are national models, especially the institutional SNPs, and the dual eligible SNPs are definitely in all markets. The chronic condition SNPs are largely concentrated in the south, but the point you raised is a good one. They are much more prevalent in urban relative to rural areas.

I think there are two sets of explanations here. There are supply side explanations and demand side ones. There are a lot of stories like Miss Eva where I think there is a lot of demand for these models, and so I think I find that explanation less compelling. I think

it is more of a supply side story, whether it is payment issues, regulatory, or just the economics of trying to have a plan that is more diffuse in a rural area.

So I do think this is an area, assuming the models meet the other criteria we have been talking about today like full integration with Medicaid and all these other conditions, that we definitely need to address.

Mr. SMITH. Sure.

Dr. FENDRICK. I think your question brings up this point about extending healthcare coverage to a broader segment of healthcare services. As you can see in my testimony, the V-BID MA demo model focuses on high-value services, high-value providers, but we worked very, very hard to include expansion of supplemental benefits. So I see patients like Miss Eva every week. And if for some reason we figure out a way to get her her medications or get her specialty visits, but she has no way to have transportation to them, the whole thing falls apart.

So one of the more interesting aspects as we hope the MA demo goes nationally, that instead of maybe saying that you should go to this hospital or use this medication, that maybe the demos will focus on these supplemental benefits like transportation and other types of services that may not be considered in the sweet spot of the realm of typical insurance designs.

Mr. SMITH. Thank you. Because I think there are a lot of great stories to tell about overall access and affordability within the fiscally responsible way. It is just that there are still some gaps out there. So does anyone else care to comment?

Ms. JACOBSON. Yes. I will also comment that, I mean, Medicare Advantage plans as a whole, the penetration rate in places like Nebraska is fairly low, and it is generally lower in more rural areas. So this really raises the question of, well, Medicare Advantage plans in certain models like SNPs have been pretty successful and proliferating in urban areas, but like you said, they really don't exist as much in rural areas.

So it deserves some consideration of how to develop these models more broadly and make them more available perhaps to people on traditional Medicare as we learn more and more about what actual benefits help people.

Mr. SMITH. Very well. Thank you. I yield back.

Chairman TIBERI. Ms. Chu, you are recognized for 5 minutes.

Ms. CHU. Ms. Wilson, I have visited my local PACE in Southern California, and I was so impressed by the level of care that was there. They have 2,300 participants. This is the program called AltaMed, and they have 2,300 participants through eight centers in the greater Los Angeles area, 73 percent of which are dually eligible for Medicare and Medicaid. And I could see that these are some of the most vulnerable patients.

The average enrollee has nine separate medical diagnoses and has impairments in four activities of daily living, such as eating, bathing, walking, and dressing. And nearly 30 percent of AltaMed's enrollees have Alzheimer's or related dementia. Eighty-nine percent are from racial and ethnic minority groups, and 75 percent are monolingual.

AltaMed succeeds because it is dedicated to serving the entire patient, rather than focusing on one symptom at a time, and as a result their enrollees have higher immunization rates, lower emergency room and hospital admission rates and shorter hospital stays than their peer groups. And 97 percent of AltaMed's participants are able to remain in their homes with the assistance of care from PACE providers.

Now, Ms. Wilson, in your testimony you noted the importance of the interdisciplinary team in the PACE model. Can you discuss how patients with co-morbidities like the majority of patients served by AltaMed are served by this interdisciplinary team?

Ms. WILSON. Yes. The interdisciplinary team is the heart of PACE. It is a group of 11 professionals, most with advanced degrees, who sit around the table and discuss each and every patient and each and every condition or situation that may come up with that particular patient. And everybody there is a part of the team, an equal partner, including the driver, including the nurse attendant, including the physician, the physical therapist, the dietician, the master's level social worker, the recreational therapist.

All of those people sit around the table and more as is needed, and they make decisions about the person in the best interests of the person, not in the best interests of the finances of the organization, not in the best interests of staff. Sometimes the family's best interests also weigh heavily, how will the family deal with the situation that is under consideration? And so the interdisciplinary team is the heart of the program.

When I first started becoming involved with PACE, having been in healthcare for many, many, many years, I thought oh, my gosh, think of all the dollars that are sitting around that table every morning, and I didn't really think that was going to be a good use of many professionals' time.

Over the 10 years that we have been providing PACE, I have absolutely changed my mind. It is the heart of the program. It is the reason that PACE is so effective, and it is the reason that it is cost effective because the care is given at the level that is needed before there is a major crisis which necessitates a hospitalization or other very high-cost care in services.

Ms. CHU. Thank you. Thank you so much.

Dr. Jacobson, I want to address the issue of mental health disorders and the senior center enrolled in Medicare Advantage.

CareMore Center, a Medicare Advantage provider in my district, developed the Brain Health Pilot Program in Southern California that sought to treat individuals with dementia-related problems, and this pilot used teams of practitioners, including a neuropsychologist, a neurologist, pharmacists, and dieticians to educate patients and caregivers about the risk of neurological disorders and how to address them.

So the pilot found that their wraparound services had a profound effect, and there was a 57 percent increase in reported falls and a 38 percent decrease in emergency room visits, but as a former clinical psychologist, I am particularly interested in the ability of Special Needs Plans to provide coverage and care for individuals with mental and behavioral health issues.

You noted in your testimony that about 1 percent of C-SNP patients are enrolled in plans to specifically treat their mental illnesses. What information do we have, if any, about the beneficiaries enrolled in C-SNPs and D-SNPs for mental illness?

Ms. JACOBSON. To answer your question directly, we don't have that data. It is possibly something we could look into, and I am happy to talk further with your staff about that after the hearing.

There are a few things to sort of emphasize on this, though. For example, the C-SNP that you mentioned is the one C-SNP that focuses on mental illnesses. It is only available in Southern California. That again emphasizes that these plans are not offered across the country. It really depends upon where you live in terms of whether you have access to this.

We don't know, at least offhand, how many people with mental illnesses are in SNPs overall. One thing to emphasize, though, is we have noticed that people who are under the age of 65 who are on Medicare, many of whom have mental illnesses, are underrepresented in Medicare Advantage plans, and we really don't understand why they are not enrolling in Medicare Advantage plans at the same rate as other Medicare beneficiaries.

Similarly, people who are over the age of 85 are also underrepresented in Medicare Advantage plans, many of whom have Alzheimer's. So it really raises questions about what is actually going on in the Medicare Advantage plans, and we really need more information as to how they are actually treating mental illnesses and what they are offering the beneficiaries.

Chairman TIBERI. The gentlelady's time is expired. Ms. Jenkins is recognized for 5 minutes.

Ms. JENKINS. Thank you, Mr. Chair, and I thank the panel for being here.

Ms. Wilson, thanks for your testimony regarding the PACE program. In Kansas, just down the street from my Topeka office, is Midland Care Connection. It operates a very successful and growing PACE program.

In September of last year they expanded their PACE program into Wyandotte County, which is in the Kansas City metropolitan area, and they created a new grieving adult support group, and I am very pleased that they were able to do that. I really admire their work and compassion for their patients and hope that they will be able to continue growing and offering services to more Kansans.

I have a question about the expansion of PACE and your thoughts on that topic. As you can tell from the questions on Committee today, many of us represent rural communities and Midland Care PACE program there in Topeka serves rural counties in the second congressional district in Kansas. It is a wonderful program that is a real lifeline for many vulnerable seniors and people living with disabilities.

I understand that CMS issued a PACE regulation almost a year ago that is still pending. Were there any flexibilities including in that regulation that would encourage PACE programs to expand to rural areas?

Ms. WILSON. Yes. That is one of the priorities for the National PACE Association is to have that PACE regulation approved, and

the proposed rule we need to get is out, but we need to have the final rule. It should be ready to go.

All the comments are back to CMS, and there are flexibilities especially for rural areas, and that is being able to use community physicians, to be able to change the interdisciplinary team that I mentioned earlier on so that you don't have to have 11 professionals around the table, that you can have the select few that need to be there in relation to that particular resident or that particular participant and their particular issue. The CMS guidelines that would come out will be very, very helpful to expanding PACE and doing it a lot more quickly.

Additionally, the pilot programs that were approved by Congress and are still waiting to be implemented by CMS, will allow us to reach out and do many more programs and reach many more populations that we currently are not allowed to do.

So we are waiting for CMS to pull the trigger and would be happy to have NPA work with you, Ms. Jenkins, on anything that you might need in order to help your State move forward on some of those issues.

Ms. JENKINS. Excellent. We will look forward to helping you do that.

As a followup, in your role at leading age in the National PACE Association, what would have been some of the concerns that you heard from your local PACE program operators and staff regarding the burden of Federal regulations or the confusion that a lack of regulation causes on them, and what can we all do to help ease those concerns?

Ms. WILSON. Well, I don't think there is a lack of regulation ever at CMS. But the changes in regulations—let me just put it this way, PACE started as a pilot project with On Lok in San Francisco 45 years ago, and because it was a pilot project there were many, many regulations and requirements imposed upon it to see whether or not it would be reasonable to continue the program.

It obviously was reasonable, and 20 years ago the first regulations came out, and they have been in place now, the same regulations, and it is time to take a look at those regulations and to make the changes.

National PACE Association has made recommendations. We have worked with CMS to look at those regulations and to make improvements and changes to help PACE to be able to grow to simplify the regulations so that PACE programs that might serve Miss Eva as mentioned before might be able to flourish, and we need CMS to, as I said, pull the trigger.

And if you can make a few phone calls to whomever you may know in that department, then that might help them to understand the importance of their work related to the PACE Innovation Act and also the proposed rules.

Ms. JENKINS. Thank you. Mr. Chairman, I yield back.

Chairman TIBERI. Thank you. The gentleman from California is recognized for 5 minutes.

Mr. THOMPSON. Thank you, Mr. Chairman. Thank you for holding this hearing, and thanks to all the witnesses for being here.

I think this is one of those rare occasions where we found something that everybody on the Committee, irrespective of which side of the dais you sit on, agrees, and I think there are plenty of examples of us working across the aisle to try and facilitate ways to ensure that folks can get healthcare at home.

And you see it in some of the telehealth legislation that Ms. Black and I wrote, and there are just a number of examples of that, and the PACE program is right up that alley.

So I want to thank you all for what you are doing and for the testimony that you are bringing forward.

I don't have a PACE program in my district, but I know my constituents would like to be able to expand their access to healthcare while being in the comfort of their home.

And maybe starting with Ms. Wilson, can you talk about some of the hurdles that organizations may face in creating a PACE program and what Congress and/or the Administration could do to support the launch process?

Ms. WILSON. Well, first of all, help us to pass those regulations, encourage CMS to pass them.

Second of all, the process to start a new PACE program is long and arduous. It takes about 2 years. And to develop a PACE site takes between \$7 and \$9 million. That includes the upfront costs to purchase the program, purchase the land, build the building, outfit the building. And then have the money on hand because it takes 1½ to 2 years in order to break even with the current payment methodology. Those upfront costs are never reimbursed. Those are costs that not-for-profits fundraise for traditionally.

The other concern is in starting a new PACE program. CMS came out 1½ years ago saying that they had a new way for applications to be submitted and then approved. The new way is once a quarter there is 1 day, 24 hours, when you may submit electronically your application, and if you miss that timeframe by 1 minute then you must wait another 3 months.

The timeframes that are lost because some consultant didn't get their report in by 2:00 p.m. in California so that you can submit it by close of business to CMS 5:00 p.m. back here on the east coast is a real challenge. And we are starting to try to open another site in our area in San Diego, and that is the biggest concern of all of our staff.

In fact, the greatest fear is they will miss that 1 day when they "push the button," and if they miss that push the button that is another 3 months' delay, that is costs that we will be incurring for another 3 months for which we will receive no reimbursement, and we will not be able to open our program, and it will delay the entire program by at least 6 months. That is for a program that is already up and running, and we were just asking for an expansion.

Now, if you look at somebody that wants to come to your area and start a PACE program, they are starting the 2-year journey, if they forget to press that button or miss that date because of a consultant report, then they are going to be delayed, and that is time and money. That is why people don't want to do PACE programs.

It is not that they don't want to do them, it is just so onerous to start a new program that it is almost self-defeating. CMS puts

up so many barriers to beginning a program that it is incredibly, incredibly hard.

Mr. THOMPSON. Anyone else like to add anything? Everybody concur?

How about qualified personnel, qualified practitioners, is there difficulty in finding folks?

Ms. WILSON. At a PACE center?

Mr. THOMPSON. Yes, for a PACE center.

Ms. WILSON. We hire on average at our centers in California 70 professional, that is graduate-level-degreed people, and on average between 25 to 35 entry level positions. That will be food service workers, care attendants, other positions, day centers, CNAs, et cetera, that perform that level of work. But on average, 70 professional clinical personnel who serve these people on a daily basis.

Mr. THOMPSON. Thank you.

I yield back.

Chairman TIBERI. Thank you.

The gentleman from Texas is recognized for 5 minutes.

Mr. MARCHANT. Thank you, Mr. Chairman.

I just have a few questions about the Medicare Advantage Plan and its growth that is taking place. I have a district around the Dallas-Fort Worth area, suburban Texas, but I have a 30 percent participation rate. Of my Medicare eligible, there is 30 percent of that population in Medicare Advantage, and that number seems to be growing.

I think, Ms. Jacobson, you did a report. I am working off of some of your work from last year.

My question is, is there any correlation? Yet Mr. Smith over in his district has like 5 percent of people who participate in Medicare Advantage, only 5 percent that are eligible to do it.

When you look down through everybody's district, is there any correlation in the participation in these special programs that we are talking about today, is there a correlation between the participation in Medicare Advantage in those districts? Mr. Curbello has 60 percent of his Medicaid-eligible people take Medicare Advantage. Is there any correlation between any of those figures as it relates to those special programs?

Ms. JACOBSON. Yes, there is a correlation, to give a very straightforward answer, because part of why Medicare Advantage penetration and enrollment rate really differs across the country, one of the reasons is due to firm experiences in those parts of the country and just history of managed care in those parts of the country, which really differs across the country.

And another reason is payment rates. And both of those reasons would apply to both regular Medicare Advantage plans as well as special needs plans. And it makes sense that the more plans that are offered, the higher enrollment likely is going to be in those areas. So we do see that the more plans that are available in an area tend to be areas where enrollment is higher.

So in that sense, yes, you do see more SNPs in areas where you see more regular Medicare Advantage plans. And we have looked at the growth in Medicare Advantage enrollment nationally as well as in different counties. And in many counties where Medicare Advantage enrollment used to be relatively low, it has been growing

pretty quickly. But in other counties, you still see pretty low Medicare Advantage enrollment and relatively few plans. So there is quite a difference across the country.

Mr. MARCHANT. Any other comments?

Mr. GRABOWSKI. I completely agree with that. I just wanted to piggyback, that just because an area has a strong Medicare Advantage penetration and that leads to greater growth in the special needs plans doesn't mean that Medicaid is able and willing to play ball alongside it.

And I think that is a really important point, that in order for these models to really work, you need a robust SNP market, special needs plan market, but you also need that State Medicaid plan to be willing to play with them.

And I think that has been one of the real challenges with this model, SNPs have sort of followed Medicare Advantage plans in some States, like Minnesota, and there really is a robust kind of Medicaid side to this market, but that is not everywhere.

Mr. MARCHANT. And I know we don't have any jurisdiction over Medicaid. Is there a correlation between the States that expand it and the participation in these programs?

Ms. JACOBSON. That is not something that we have looked at, although I would emphasize that for Medicare Advantage and for SNPs it really is a county-by-county issue. It is not a State issue. So parts of Texas even have relatively low Medicare Advantage enrollment. But, obviously, other parts of Texas have relatively high Medicare Advantage enrollment, and you see that in many States.

Mr. MARCHANT. Thank you.

Thank you, Mr. Chairman.

Chairman TIBERI. The gentleman from Oregon is recognized for 5 minutes.

Mr. BLUMENAUER. Thank you, Mr. Chairman. I appreciate our having this conversation.

Dr. Fendrick, I appreciate having you back. I continue to be quite enthusiastic about the simple logic that you described. Some of the work that is underway, I appreciate you giving us some specifics that you think might make a difference to accelerate the progress.

And, Mr. Chairman, I would hope that this would be an area on which we could spend a little more time. As you know, Congresswoman Black and I have had legislation in the last couple sessions. We are fans. We think that this can be advanced outside of the scope of some of the things that get us tripped up around here. And I think there is some really powerful evidence that we can help provide better care and bend the cost curve.

But there is just one area, Doctor, that I would seek your advice and counsel, because there are questions about the applicability for VBID in very low-income populations who aren't involved with a copayment, can't afford more, some of them have no cost sharing.

Do you think there are ways that this can be applied in value-based design to be able to get around this, to be able to provide the power of the concept for people who don't have that type of copayment or capacity to pay more?

Dr. FENDRICK. So, first off, thank you for the kind words. I am happy to be back, and it is a great pleasure to be talking about one of the rare bipartisan healthcare reform ideas. And I appreciate

your work and Representative Black's and others on the Committee to make this happen.

So we have studied the impact of increases in cost sharing, because that is what has largely happened in this country. And it comes as no surprise, and you don't need advanced degrees like my fellow panelists to know that if you make people pay more for something, they will buy less of it. And poor people are impacted by higher prices more than rich people are.

So we have focused very, very much on those people with multiple chronic conditions and those who are economically vulnerable and have basically tried to implore public and private payers, if you can't extend VBID principles to everyone, you should probably extend VBID principles and lower cost sharing to the people who would benefit the most, and those are the sickest individuals and those who do not have economic resources.

The good news, as we heard, such as the PACE program, there has already been integration of VBID principles to make sure that those who cannot afford essential services can. That doesn't mean it is happening all over the Nation.

I think it is particularly germane regarding prescription drugs in this program, and we have focused a lot of our attention on trying to extend this clinically nuanced cost-sharing issue to the issue of Part D drugs. We know that there are a lot of low-income Medicare beneficiaries who are either cutting their pills or taking them every other day or not taking them as their doctor or nurse practitioner prescribed that they do that. And there have been external influences, like patient assistance programs and charity programs, to help bridge that gap.

It is our hope that if value-based insurance designs are put in place, whether it be for middle income or low income, that those services that are deemed to be highest value would have zero cost sharing, regardless of income, which is the case for many preventive services in Medicare now, much to the credit of this Committee.

And we are hopeful that as VBID ideas are extended, particularly for those extraordinarily well-established, high-value services, to Dr. Gretchen Jacobson's point, I don't want to get into the areas where there is controversy when there is 20 years of evidence of quality metrics in the Medicare program. Let's start with those low-lying fruits. And if we can't extend them because of fiscal issues to every Medicare beneficiary, then obviously the best place to get a return on investment would be to focus those on the populations who are most likely to achieve benefit, and those are the low-income folks.

Mr. BLUMENAUER. Well, I am hopeful that we won't ignore the areas of controversy, but I subscribe wholeheartedly to the notion let's start where we can, establish the principles, spread the benefit. But having a sense of how we can develop the nuance for the lower income where there might be some way of having a more powerful incentive or some of the nuance through the program administration, if you could lend some thought to that.

Dr. FENDRICK. I will just quickly say that, not being a legislator or a lawyer, not understanding all the regulations, in the commercial sector, where the VBID experience is much better stud-

ied and has wider implementation, there are public and private employers that are extending greater subsidies to employees who are, say, hourly compared to salary.

Mr. BLUMENAUER. I understand. I just would like your reflection at some point about where there is no cost sharing, very low income, how we can refine, perhaps, that incentive.

Mr. Chairman, thank you. I appreciate the conversation, and I hope that we can dig a little deeper here. This is very helpful.

Chairman TIBERI. Thank you. Me too.

The gentleman from Wisconsin, Mr. Kind, is recognized for 5 minutes.

Mr. KIND. Thank you, Mr. Chairman.

I want to thank our panelists for your testimony here today.

I represent a very large rural western Wisconsin district. And we are kind of proud in Wisconsin for some of the unique pilot SNP programs that we have, especially with the dual eligibles back home. We have about 20 percent penetration with MA plans. Those numbers have been going up even in the large rural area. And I am a big believer in trying to move the system to a more value, more quality, more outcome-based incentive system, whether it is through delivery system reform or payment reform.

Dr. Fendrick, with the value-based insurance plans out there, just how much more can we be pushing? How quickly? And when can we start bringing this, really, to capacity so that we start seeing better results at a better price?

Dr. FENDRICK. I appreciate that comment. I think a lot of people were talking about alignment in a different context earlier in the panel.

I want to talk about alignment to you as I know you have been pushing for value in caring more about health than costs even though we have to be fiscally responsible and clinically nuanced at the same time.

Most of the major reforms going on in American healthcare, and particularly Medicare, are the supply side or provider-facing initiatives trying to get clinicians like myself to behave different and better. And I think we have made marginal success in this regard moving in that direction.

We have not done the same for the patient-focused side. We have continued into this kind of one-size-fits-all design. And I think for me the end-all is to find a situation where clinicians, hospitals, SNPs, ACOs, whatever, are aligned completely with the patient. Imagine now, Mr. Kind, I am paid a bonus to get my patients with diabetes to the eye doctor and my patients are in a plan for which they can't afford the deductible to go to the eye doctor for that exam.

So my view about alignment is not more of these granular issues. Imagine a situation, which we are moving slowly in a bipartisan way toward, where both the providers and the patients are aligned over health, understanding that we have to be fiscally responsible in this regard.

Mr. KIND. Well, we have numerous alternative payment methods out there, different pilots. I think one of the best things we created in the Affordable Care Act was the Center on Innovation so we can start experimenting in these areas. But is there more, is

there another pilot or something that you envision that the Center on Innovation ought to be setting up and working with in order to move down this path?

Dr. FENDRICK. Well, I will stay with the Chairman's theme of integration. I think that one is not so much creating new pilots but getting pilots to think about one another.

And since many of you are from rural areas, one of my favorite demos is the Pennsylvania Rural Health Model, which has been taken in a bipartisan way in that State—again, many, many rural districts there—to try to preserve and protect access to care for many of those individuals who live in those areas, but being fiscally responsible in that way.

And this is largely at this early stage a way to deal with hospitals and clinicians there. And they are only just now thinking about how to better engage patients to get care locally when it is best for them, and when it is best for them in that rare instance where they have to go to a center of excellence to go elsewhere.

Again, many of these conversations are driven by dollars, and I love your theme of the fact that we have to think about health as well as dollars in moving these ideas.

Mr. KIND. Mr. Grabowski, you have already mentioned about the importance of greater clinical financial integration leading to better results, and that I think is particularly pertinent with the dual SNPs as well, the Medicaid, Medicare overlapping in that. What more can we be doing in order to encourage that type of integration of services?

Mr. GRABOWSKI. Yes, I touched on this earlier in my remarks, but I really think pushing on Medicaid, once again, getting beyond simply having these contracts that consist of case management. I really want true alignment where the Medicaid program is actually working closely with the plan, and the dual-eligible SNP actually has some control over the finances, a truly integrated financial product.

Another model that can often work is where the same managed care company has the dual-eligible SNP and a Medicaid plan and there is the opportunity to kind of align there. But if they are not kind of at risk for Medicaid finances, you are not going to get that meaningful financial alignment up top, and that is not going to work at the delivery level.

Mr. KIND. How are we doing overall as far as the collection of data when it comes to quality measurements? Are we getting better?

Mr. GRABOWSKI. I think we are getting better, but I think in regards to this population, we have a long way to go. We have sort of had a one-size-fits-all model, as Mark just said. That is really challenging, because this is a really unique population with really unique outcomes. And the thought that a 70-year-old Medicare beneficiary who is healthy will have the same kind of quality outcomes as an 80-year-old diabetic or an individual with dementia just isn't the case.

Mr. KIND. Yes. Thank you, Mr. Chairman.

Chairman TIBERI. Thank you.

Mr. Higgins, you are recognized for 5 minutes.

Mr. HIGGINS. Thank you, Mr. Chairman.

You have all studied the Medicare Advantage program pretty extensively. And about 31 percent of the Medicaid—Medicare population is enrolled in Medicare Advantage programs. Pretty accurate?

Ms. JACOBSON. Did you say 1—it is about one-third now.

Mr. HIGGINS. It is about one-third. Okay.

A little less than 2 million are enrolled in special needs programs. That is about 12 percent of the Medicare Advantage population. As this population is frail and chronically ill, I presume that consumes a disproportionate amount of the Medicare Advantage dollar.

Do you have any estimates as to what was spent on the Medicare Advantage special needs program last year or in 2015?

Ms. JACOBSON. We don't have specific figures of how much, that is not publicly available data, of how much plans, specific plans receive.

Mr. HIGGINS. Well, why wouldn't that—I mean, it is a public program. Why wouldn't that be—if we are looking at designs for greater efficiency in the delivery of services and lowering costs, it would seem to me that the amount of money that we spend each year would be readily available, because that would be an important number to either conclude that we are doing well with it or we need to do better.

Ms. JACOBSON. So in the past, CMS has released some data on the bids Medicare Advantage plans would get, which would help to get at how much they are paid.

The issue is that it is not—the data that has been released is not granular enough for us to look at what—how much SNPs in particular have been paid.

Mr. HIGGINS. Could we safely assume, then, that it is—it has to be a very high number as compared to the rest of the Medicare Advantage population, right?

Ms. JACOBSON. Yes.

Mr. HIGGINS. Okay.

Medicare Advantage is administered by private insurance companies. How big a player is UnitedHealthcare in the Medicare Advantage special needs plans?

Ms. JACOBSON. UnitedHealthcare is the dominant insurer firm offering the institutional SNPs. They also offer many chronic care SNPs.

Mr. HIGGINS. Is 20 to 25 percent of the special needs population on the Medicare Advantage program, are they covered by UnitedHealthcare?

Ms. JACOBSON. A fairly significant portion, yes, are covered by United.

Mr. HIGGINS. Do you know what is going on with UnitedHealthcare right now? The United States Department of Justice has just joined a lawsuit against UnitedHealthcare for allegedly defrauding the Medicare Advantage program out of hundreds of millions and potentially billions of dollars in each of the last 10 years.

When we look at designing a program to discover value-based insurance designs by using financial incentives to promote cost-efficient high-value rather than low-value healthcare services, it would seem to me that is a major issue. As students of the Medicare Ad-

vantage program, are you familiar with the details of that investigation and its implications relative to funding that program?

I am not picking on you.

Ms. JACOBSON. I am well aware that the investigation is ongoing.

Mr. HIGGINS. Are the other private insurance companies that are involved in the Medicare Advantage program for special needs, are they also being looked at for also defrauding, overcharging the American taxpayers in Medicare Advantage under the special needs program?

Ms. JACOBSON. I do not know what other companies are currently being looked at that have not been announced.

What I would emphasize is the Medicare Payment Advisory Commission, as you may know, has done a lot of work looking at coding intensity.

Mr. HIGGINS. I understand. This is fraud. This is stealing money from the American people in the Medicare Advantage program. It is a different issue altogether.

I yield back.

Chairman TIBERI. The gentleman's time has expired.

Mr. Meehan is recognized for 5 minutes.

Mr. MEEHAN. Thank you, Mr. Chairman. I want to thank you, frankly, for holding this hearing, which I think is really focused on something which is so important, which is this effort to assure that we continue to look for innovative ways to deliver quality care while at the same time looking for ways to hold down costs. And I am moved by a couple of realities.

One, the recognition that when we get to the Medicare Advantage population, we have about 50 percent that consume about 3 percent of the costs, and then a very small percentage, 10 percent, that account for about the other two-thirds. So we know we are dealing with a very targeted population to begin with.

And what I have found actually sort of heartwarming, and it is sort of counterintuitive, you would think that Medicare Advantage falls disproportionately, that the wealthier you are, the more likely you are to purchase the plans. And yet, to the extent that I have been able to look at it in my own district, the people who have taken the time to invest in getting these plans are not always people with the highest means. So there is an effort on the part of those who want to be consumers of it.

But, Dr. Fendrick, I want to focus on what your testimony was earlier, about this being directed toward the patients, not just specifically the payer. One of the things that we are looking at is legislation that would create more flexibility, to prevent chronic illness or improve care coordination, those kinds of things.

Would you speak to that issue of flexibility that you would like to be able to see so we can deliver to this chronic group and really not just cost savings, but it is quality, it is these people are better off.

Dr. FENDRICK. Right. So excellent point.

So, first off, healthcare is very complicated. Who knew, right? So it has been a longstanding fact that a significantly small portion of populations in Medicare and commercial expend a very, very large part of the healthcare pie. Most of the fabulous innovation

that is going on that allows me to better treat these patients—and I congratulate Congress for the bipartisan passage of the 21st Century Cures Act, which allows even a greater influx of innovative funds to help me take care of my patients better.

So that is all well and good for those of us who are trained to improve the quality and length of life. Almost all of these innovations, with very few exceptions, come at a significant expense, which requires that tension that I prefer you to have rather than I, which is we want to do the best for our patients, but we also have to be fiscally responsible, which you mentioned very clearly in the call of this hearing.

So as the practice of medicine moves forward at a rapid pace, Star Wars, we have precision medicine. We have genetic medicine. The delivery system, in my opinion, is like the Flintstones, right? So the delivery system has not been able to catch up to the incredible science that we have had.

So we have one of two choices. One is that we slow down the innovation in the Star Wars medicine, which I would not advise, or we continue to have conversations like we are having today and have experts like I have to my right to think about ideas that allow us to have the delivery system catch up to the precise example that you raised.

And, again, going back to 1965, there was this important issue to make sure that every Medicare beneficiary had the same benefit design. I would argue, 2017 and beyond, given that we can't give all things to all patients, that instead of blunt instruments, a much better approach would be one that is individualized, similar to the situation that we heard of in the PACE programs.

Mr. MEEHAN. Actually, part of the legislation is to create supplemental benefits for those that are chronically ill sort of to address that. Do you think that would go toward the objective that you are articulating?

Dr. FENDRICK. Absolutely. And, again, it is baby steps. But the initial VBI MA demo, not just that includes services and providers, CMMI, was very, very careful to follow advice from this Committee to allow the demo plans to extend supplemental benefits as part of the demonstration package, a broader view.

Mr. MEEHAN. Thank you for your testimony.

Mr. Chairman, I yield back in light of time.

Chairman TIBERI. Thank you.

Mr. Reed.

Mr. REED. Thank you, Mr. Chairman.

I was just going to listen today, but, Dr. Fendrick, you touched on something and I want to follow up on my colleague from Pennsylvania on it, looking at it from a beneficiary patient perspective.

One of the things I firmly believe is that people react to their own fiscal condition. If they see money in their pocket, it seems to generate more behavioral change, in my opinion, than other items in this arena.

And so, are you aware of any studies that talk about human behavior and the impact that having a carrot approach to this may have a beneficial income on a reimbursement model? You are talking about in some of your testimony, for example, the diabetics and having foot and eye exams with no copays, that type of thing, yes,

that is a bottom line financial impact to an individual, but do they really see it?

And what I mean by that, I will tell you a story. When I was a kid, I was raised by a single mom, youngest of 12, and every time we went to the bank to pay the bills each month she would cash her checks to hold the cash and then give it back.

Is there any type of creative, innovative ways that we could talk about in regards to reimbursing patients for seeing a doctor and getting followup care, medication adherence? I have even had talks with CEOs of different carriers about even giving them a gift certificate for doing that. And they told me that regulations in New York prevented them from doing that, or maybe they are Federal regulations.

Does that carry any weight, that kind of nominal impact on human behavior? Do you think that could change the curve?

Dr. FENDRICK. So I should bestow a degree of behavioral economics for that. I mean, David and others are experts here on that.

Mr. REED. Well, let's go to David, too, after you. But, please, from your patient perspective.

Dr. FENDRICK. So first off, the Kaiser Family Foundation has all this information, a lot of good information in the testimony and elsewhere, to answer these types of points.

I do believe strongly that, particularly in the low-income folks that we talked about earlier, something as low as a dollar matters. So I have seen Medicare Advantage patients who are faced with \$4 copays for drugs that everyone in the exam room knows will be meaningful changes, but you never want to be in the situation to either pay rent, buy food, or fill your prescription, which is why we argue for these types of things.

But I want to make sure, it is not all things for everyone. I would like to start with those conditions and those services for which there is no doubt that they should be prescribed and used in those situations, which is where the nuance comes in.

In some commercial settings, we have gone beyond free and we have actually paid people to do certain things like quit smoking or take their prenatal vitamins or other types of things.

Mr. REED. And we have seen a positive change.

Dr. FENDRICK. We do. But we also have what I call the frozen carrot, that if people are given an advantage and lower cost sharing to do certain things and they don't, they should also be accountable for that.

Mr. REED. They get the stick.

Dr. FENDRICK. I call it a frozen carrot. I would rather call it that.

Mr. REED. A frozen carrot. Very good.

David, could you offer on that?

Mr. GRABOWSKI. Absolutely. I come to Congress and a behavioral economics lecture breaks out here. This is great.

As Mark described, I really like these programs. There have been a lot of positive studies. I am thinking of the work of Kevin Volpp at the University of Pennsylvania where he has paid patients to take particularly high-value drugs, and it is VBID on steroids basically and it has shown to be very effective in those applications.

So I think you raise a really good point, Mark, that accountability is key in these kinds of programs as well. But I do think if there is going to be huge costs to the healthcare system of drug non-adherence here, we want to make certain that we are potentially incentivizing individuals to adhere to their drug regimen.

Mr. REED. And would you agree, David, that even a dollar would matter to a lot of those individuals, change their behavior to adhere to their medications?

Mr. GRABOWSKI. It absolutely does.

Mr. REED. You know it does.

Dr. FENDRICK. I want to say one thing that you may find very interesting, as the argument breaks out here. In a large commercial experiment we offered Americans in really good insurance plans who had heart attacks their drugs to prevent their second heart attack at no cost to them. They only took them 50 percent of the time.

So we need to go beyond financial incentives, particularly the carrot, as you described, communication, literacy, transportation, not just drug reductions in copays, to make this work. They took it more often than when they had to pay for it, but still we have a long way to go.

Mr. REED. I appreciate that. And being new to the Subcommittee, I appreciate the opportunity to continue to learn on this, and I appreciate the opportunity to participate.

Thank you, Chairman.

Chairman TIBERI. Well, thank you, Mr. Reed. We have about a minute left to go vote, so perfect timing on your part.

Dr. Fendrick, Dr. Grabowski, Ms. Wilson, Dr. Jacobson, you guys were outstanding. And Mr. Levin and I both were chatting here, and you have really helped bring along the debate as we move to making Medicare more efficient both for taxpayers and for the patients that you see, Dr. Fendrick. So we appreciate your testimony today. Your answers were very good. We look forward to working with you in the future.

With that, please be advised that Members will have 2 weeks to submit written questions to be answered later in writing. Those questions and answers will be made part of the formal hearing record.

With that, the Subcommittee stands adjourned. Thank you all.

[Whereupon, at 4:28 p.m., the Subcommittee was adjourned.]

[Questions for the Record follow:]

Questions for the Record for A. Mark Fendrick, MD

Health Subcommittee Hearing on Promoting Integrated and Coordinated Care for Medicare Beneficiaries

Subcommittee on Health (Minority):

Question: *In keeping with value based care design, if we know that costs can be a deterrent for people getting necessary care, how can we put more effort into ensuring that very low income seniors who are eligible for Medicaid cost and coverage assistance are incentivized to enroll in these programs?*

The best way to ensure that low income seniors take advantage of the enhanced access to high value services and high performing providers specified in V-BID programs is to include V-BID principles in a standardized benefit design. Such an approach has been applied for specified primary preventive care services for commercial plans in the Affordable Care Act (sec 2713) and to a lesser extent for the Medicare program (sec 4104). In these instances, the entire insured population have barriers reduced for these specified high value clinical services.

The evidence on V-BID in the commercial insurance marketplace clearly demonstrates that those who are financially vulnerable and with those chronic diseases benefit the most from the V-BID cost-sharing reductions. Best practices for V-BID the Medicare program will be identified as the clinical and economic impacts of the Medicare Advantage V-BID Model Test become available. While a 'needs based' implementation of V-BID might target those low income seniors likely to benefit from the V-BID program, the added logistical effort needed to operationalize such a targeted implementation might be problematic, and prone to criticism. Given the relative low initial cost, and likely net savings incurred from a population based program, a V-BID plan that is made available to all seniors is recommended. The effective communication of the benefits of such a program – especially to those most likely to benefit – is essential.

Question: *Do you think there are approaches Congress could take to improve quality while reducing costs for prescription drugs?*

Access to affordable prescription drugs is an extremely important and provocative issue. I realize that the Committee has addressed this topic in great detail. Any initiative that could better ensure that patients receive the right drug at the right time (at an affordable price) would both improve quality of care and lower costs, largely by increasing the likelihood that specific drugs are used only when clinically appropriate, thus adding efficiency. I would be very pleased to discuss my views in more detail with the Committee at any time.

A few key points – many included in my written testimony.

1. **An important distinction needs to be made between the cost of prescription drugs to the Medicare Program and cost to the Medicare beneficiary.** Rising out-of-pocket costs are a top concern for Medicare beneficiaries and can be more immediately and effectively addressed than drug pricing for the Medicare Program. Beneficiary cost-sharing can (and should) be reduced for clinically indicated drugs through the implementation of condition-specific value-based insurance design (V-BID) programs (as are now being studied in the Medicare Advantage V-BID Model Test). Actuarial analyses have demonstrated that increases in the use recommended prescription drugs for several chronic conditions, improves clinical outcomes, lowers out of pockets costs, and in some instances reduces total Medicare expenditures. Such an approach would align with current alternative payment models being implemented across the country.
2. **Value-based pricing.** Many proposals have been put forth for the Medicare program to use “value-based” pricing for prescription drugs. This is a very complicated issue, that is unlikely to be resolved for some time. I support any effort to connect health care expenditures to improvements in patient-centered outcomes. Thus, it is important to follow a guiding principle when considering value-based or outcomes-based pricing for any medical service. The clinical value of a clinical service (e.g. drug, visit, procedure) depends on the consumer using it, as well as when, where, and by whom the service is provided. For drugs specifically, the value of a prescription medication depends 1) on the condition treated (e.g., life threatening or not) 2) how well the drug works (e.g., cure or not), and 3) whether there is an alternative treatment option. Most value-based pricing proposals do not include all 3 of these important determinants of a drug’s value.
3. **Patient Assistance Programs.** Patient assistance programs serve to address salient concerns around cost-related access to clinically indicated prescription medications. However, some patient assistance programs do not take into consideration the clinical indication for a specific drug (e.g., copayment cards for branded medications when generic equivalents are available), these programs may undermine health plan formularies and speed members toward deductibles and out-of-pocket maximum amounts they might not otherwise satisfy.

Plans, pharmacy benefit managers, and manufacturers could minimize potential harm through new partnerships that facilitate the use of patient assistance when high-cost medications are used in high-value clinical scenarios. A “truce” might include the following provisions, each of which could serve to enhance access to clinically indicated therapies and decrease the financial and logistical burden on patients/families and their clinicians:


Payers would accept the use of support for consumer cost-sharing when a particular medication is clinically indicated and has low potential for inappropriate use. This would mean supporting patient access to high-value medications when clinically appropriate and forgoing utilization management (e.g., step therapy, prior authorization, formulary exclusions, etc.) in these situations. Payers might also encourage their contracted

providers and care managers to connect patients to patient assistance resources when clinically appropriate.

Manufacturers would ensure information on clinical appropriateness – including scenarios where a medication is not clinically appropriate – is well-communicated in patient assistance materials. For manufacturer-administered programs serving those with commercial coverage who are underinsured, applications might inquire as to whether first-line treatments had been appropriately tried.

Specifically, in Medicare Part D, the Office of the Inspector General (OIG) could update its guidance to enable clinically nuanced patient assistance programs, while maintaining the “firewall” between manufacturer donations and patient-facing grantmaking. This would give charities the option to prioritize access to assistance based on clinical need – not simply the timing of the application for assistance. If such arrangements were permissible, a charitable patient assistance foundation could, for example, choose to prioritize assistance for a patient with Rheumatoid Arthritis (RA) whose care had proceeded in accordance with the guidelines of the American College of Rheumatology or for a patient with cancer who is appropriately receiving a targeted therapy given the presence of a particular biomarker. As a result, existing donor dollars might do more good for more patients. Ensuring that limited donor dollars buy as much health as possible could be worth the additional administrative expense associated with such an arrangement.

Advances in precision medicine have spurred calls for greater use of benefit designs that encourage and enable patients to receive the right care, at the right time, in the right place, at an out-of-pocket price they can afford. Payers, purchasers, pharmacy benefit managers, patient assistance charities, and pharmaceutical manufacturers could find common ground by piloting patient assistance programs that complement these efforts. Through collaboration, stakeholders can steward limited health care resources while ensuring that out-of-pocket costs never prevent patients from accessing high-value therapies.



Questions for the Record for David Grabowski, PhD

Health Subcommittee Hearing on Promoting Integrated and Coordinated Care for Medicare Beneficiaries

Subcommittee on Health (Minority):

Question: *How can we get more plans and programs to improve outcomes, remove silos and improve quality of care for patients, especially those that are dually eligible for both Medicare and Medicaid?*

RESPONSE: The key is encouraging more plans that are truly integrated across Medicare and Medicaid. That is, plans will only invest in improvements when they are “at risk” for both Medicare and Medicaid spending and outcomes. The first generation of Medicare Advantage Special Needs Plans (SNPs) were not well-integrated. Beginning in 2010, the Congress required SNPs to contract with the state Medicaid programs. This was a step in the right direction. Unfortunately, most SNPs simply established contracts that involve case management of Medicaid services. These SNPs are not fully at-risk for Medicaid spending or outcomes. As a result, these SNPs do not meaningfully integrate Medicare and Medicaid services.

Going forward, I could envision two different approaches towards true integration. First, the SNP could contract with the state to go “at risk” for all Medicaid spending. With this model, the SNP would be at risk for the full set of Medicare and Medicaid services. They would have a strong incentive to provide services in the highest value setting. A series of performance benchmarks would ensure that the SNP provided good quality care. Second, a related approach would be for the same insurer to manage both the SNP and the Medicaid plan. Given this insurer is “at risk” for both programs, they would have the incentive to coordinate services across the two plans.

Question: *Do you have suggestions for data or additional reporting that would help inform the discussion around improving care coordination for dual eligible beneficiaries?*

RESPONSE: Over time, the Centers for Medicare and Medicaid Services has added Healthcare Effectiveness Data and Information Set (HEDIS) quality of care measures applicable to SNPs. Using these data, SNPs can be evaluated on their care models and structure and process measures. Additionally, these SNP process measures are a part of the CMS Medicare Advantage star system.

As an initial comment, we need further research on developing outcome measures that are specific to beneficiaries with special needs. Additionally, it remains challenging for beneficiaries to compare SNPs with traditional Medicare Advantage plans. Although the SNP-specific HEDIS measures are collected only for the SNP beneficiaries, the data reported on the Medicare.gov website can include non-SNP specific measures at the contract-level (which includes both SNP and traditional Medicare Advantage enrollees). Thus, it is not always clear to the beneficiary


whether the federal website is measuring plan (SNP) or contract level quality. Second, there are very few quality measures that are collected uniformly across SNP and traditional Medicare advantage plans to facilitate comparisons. If beneficiaries are going to choose a SNP rather than a traditional plan, they should be able to see the tradeoffs on the Medicare.gov website.

Question: *What recommendations do you have for how Congress and the Administration might enable D-SNPs to more fully integrate Medicare and Medicaid benefits and services?*

RESPONSE: One recommendation is to shift financial responsibility for the care of the dually eligible population, including long-term care, to the D-SNPs. The idea is that this shift would improve the coordination and integration of care for dually eligible enrollees because the D-SNP would manage all spending for dual eligibles. For example, the D-SNP would be held accountable for both medical and long-term care outcomes.

Question: *What recommendations do you have for increasing state participation in integration efforts?*

RESPONSE: True integration occurs when financing is blended across Medicare and Medicaid services. This financial coordination can occur through a federal or state plan. Completely turning the financing of dual eligibles over to the federal government via the D-SNPs is one mechanism to increase state participation. If the federal government paid a higher share of the costs (relative to the current model), then it would offer fiscal relief to the states and thereby increase participation. During recent budget shortfalls, many states have struggled to maintain coverage and benefits for Medicaid beneficiaries. This shift would place more of the costs (and risks for future cost growth) on the federal government.



Questions for the Record for Gretchen Jacobson, PhD

U.S. House of Representatives, Committee on Ways and Means, Health Subcommittee Hearing on Promoting Integrated and Coordinated Care for Medicare Beneficiaries

***Question:** As more beneficiaries choose MA, what should we as policy makers and stewards of tax payer dollars think about?*

Medicare Advantage enrollment is projected to continue to grow over the next decade, rising to 41 percent of all Medicare beneficiaries by 2026.¹ As private plans take on an even larger role in the Medicare program, it will be increasingly important to continue to assess how well Medicare Advantage is working for enrollees with regard to premiums, out-of-pocket costs, benefits, quality of care, patient outcomes, and access to providers. It will also be important to assess how well Medicare's current payment methodology for Medicare Advantage is working to hold down Medicare spending. However, the data needed to evaluate many of these facets of the Medicare Advantage program is often lacking. In particular, payments to Medicare Advantage plans, enrollees' health status (or risk scores), and patient outcomes are typically not publicly available.

It will also be important to address issues that we know are not working well for beneficiaries. Specifically, seniors have said that they do not switch plans or assess whether other plans may better fit their needs because they find the process of sorting through their plan options to be frustrating, confusing, and/or overwhelming.² Ensuring that beneficiaries can easily switch plans not only allows beneficiaries to leave plans not serving them well, but also incentivizes plans to provide efficient, high quality care at the lowest price, which in turn helps to control total Medicare spending. Only about 10 percent of Medicare Advantage enrollees switch plans each year.³ Policy makers could help to address this issue by requiring the Centers for Medicare and Medicaid to overhaul the Medicare plan finder on medicare.gov to make it easier for beneficiaries to compare plans. This remodeling would ideally include adding important information that is currently absent, such as the plans' provider directories, and clarifying information that is currently challenging to analyze, such as benefits and out-of-pocket costs.

Policy makers may also wish to examine policies or other factors that may make it difficult for Medicare beneficiaries to switch between Medicare Advantage and traditional Medicare. Each year, less than five percent of Medicare Advantage enrollees switch to traditional Medicare, and this percentage does not markedly change even as premiums for Medicare Advantage plans increase.^{4,5} One factor that may contribute to the lack of movement from Medicare Advantage to traditional Medicare is that beneficiaries may not be able to purchase Medigap supplemental coverage policies outside of the guaranteed issue period.⁶ In many states, Medigap insurers are not required to issue policies, and may use underwriting, for beneficiaries who have been on Medicare for a year or more.⁷ Purchasing a Medigap policy may be particularly important for beneficiaries with significant healthcare needs and other beneficiaries who would benefit from a limit on out-of-pocket expenses under traditional Medicare.

Medigap also plays a more important role now to beneficiaries in traditional Medicare than it did a decade ago since the percent of seniors with supplemental retiree health insurance has steadily declined.⁸

As Medicare Advantage plans take on an even larger presence in the Medicare program, careful stewardship and oversight by policy makers, in concert with greater transparency on the part of plans, are needed to make sure that plans provide value to the Medicare program, and the 57 million beneficiaries it covers.

Question: *Please provide more information about coding intensity within the MA plans. What is the current state of coding within the MA program and what challenges do MA programs face with coding intensity?*

The Medicare Advantage risk adjustment system is designed to compensate plans that enroll sicker-than-average Medicare beneficiaries by paying plans more for people with greater healthcare needs and paying less for people with fewer healthcare needs. The risk adjustment system uses diagnostic information to assign Hierarchical Condition Categories (HCCs) to each Medicare Advantage enrollee. For each additional HCC assigned to an enrollee, capitated payments to the enrollee's plan increase. For example, according to the Medicare Payment Advisory Commission (MedPAC), a Medicare Advantage organization may be paid about \$5,555 per year for an 84-year old male enrollee, but would receive an additional \$1,030 per year for the enrollee if he had diabetes without complications.⁹ MedPAC has estimated that an additional HCC typically adds between \$1,000 and \$5,000 per person per year, giving plans a strong financial incentive to identify and report multiple diagnoses. In contrast, no corresponding financial incentive exists in traditional Medicare, and instead, diagnostic information for beneficiaries in traditional Medicare has been shown to be incomplete.¹⁰

While the data on plan payments and patients' risk scores¹¹ is not publicly available, two studies, authored by people with access to the data, have examined this issue and have found that risk scores have increased faster among Medicare Advantage enrollees than among beneficiaries in traditional Medicare.^{12,13} MedPAC found that the risk scores for Medicare Advantage enrollees increased by about 10 percent more than the risk scores of beneficiaries in traditional Medicare under the 2015 risk adjustment model;¹⁴ the other study found similar results.¹⁵ The Centers for Medicare and Medicaid is required to reduce payments to plans by 5.66 percent in 2017 to account for coding intensity differences between Medicare Advantage and traditional Medicare. This required reduction in payments will leave about a 4 percent difference, on average, in coding intensity between Medicare Advantage plans and traditional Medicare, meaning that Medicare Advantage plans will receive about 4 percent more, on average, than they otherwise would have received absent coding differences between Medicare Advantage and traditional Medicare.¹⁶

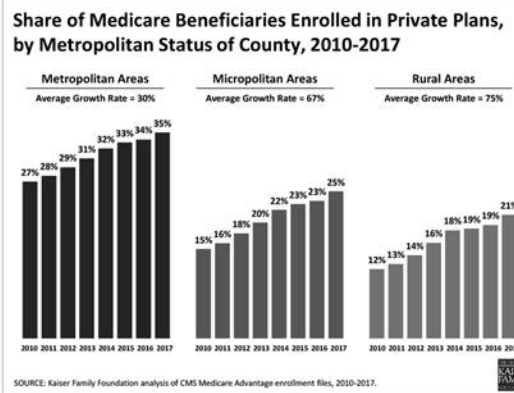
It is worth noting that both studies found that the amount of coding intensity greatly varies across plans, with risk scores in some plans increasing much faster than in other plans. Neither study was able to determine whether the coding intensity was due to plans more accurately capturing conditions or to fraud.¹⁷ However, both studies show that a Medicare beneficiary in traditional Medicare would likely have a higher risk score (poorer health) if they were enrolled in a Medicare Advantage plan.

Since increasing the number and severity of diagnoses for Medicare Advantage enrollees would increase payments to Medicare Advantage plans, coding intensity would also increase Medicare spending. While such estimates rely on many assumptions, one researcher estimated that coding intensity will increase Medicare spending by about \$200 billion between 2017 and 2026.¹⁸ Increasing Medicare spending by this magnitude would impact the life of the Medicare Trust Fund and also result in higher Part B premiums for all Medicare beneficiaries.

Question: *Why are MA and SNPs plans having trouble gaining hold in rural areas? Please identify ways to extend MA and SNPs to rural areas.*

In 2017, over one-third (35%) of Medicare beneficiaries in metropolitan areas are enrolled in Medicare Advantage plans while about one-fifth (21%) of beneficiaries in rural areas are in Medicare Advantage plans. While the share of Medicare beneficiaries enrolled in Medicare Advantage plans has been lower in rural areas than metropolitan areas for at least the past decade, Medicare Advantage enrollment in

rural areas has been growing at a faster rate than Medicare Advantage enrollment in metropolitan areas. Between 2010 and 2017, in rural areas, the percent of Medicare beneficiaries enrolled in Medicare Advantage plans increased from 12 percent to 21 percent, a 75 percent increase. Over the same time period, in metropolitan areas, the percent of Medicare beneficiaries enrolled in Medicare Advantage plans increased from 27 percent to 35 percent, a 30 percent increase.



Some market features, such as plan availability and out-of-pocket costs, may help to explain the difference in Medicare Advantage enrollment in rural areas compared to metropolitan areas. Medicare beneficiaries in rural areas have access to 10 Medicare Advantage plans, on average, whereas beneficiaries in metropolitan areas have access to 21 plans, on average, in 2017.¹⁹ Additionally, the Medicare Advantage plans in rural areas are offered by fewer firms than the plans in metropolitan areas (3 firms in rural areas compared to 7 firms in metropolitan areas in 2017).²⁰ It may be more difficult for insurers to set up new plans and create provider networks in rural areas compared to metropolitan areas because there are often fewer healthcare providers in rural areas. Yet, many Medicare Advantage insurers are active in both rural and metropolitan areas, and the vast majority of Medicare beneficiaries in rural areas (96%) have access to at least one Medicare Advantage plan in 2017.²¹

Another possible reason for lower Medicare Advantage enrollment in rural areas than in metropolitan areas is that enrollees in rural areas may pay more out-of-pocket than enrollees in metropolitan areas. Medicare Advantage enrollees in rural areas paid monthly premiums that were 68 percent higher, on average, than the average premiums paid by enrollees in metropolitan areas in 2017 (\$57 per month, on average, paid by enrollees in rural areas compared to \$34 per month, on average, paid by enrollees in metropolitan areas).²² We do not know how the cost-sharing, benefits, quality of care, or provider networks differ between plans offered in rural areas versus metropolitan areas – factors that, in addition to premiums, could greatly affect beneficiaries' total out-of-pocket costs for Medicare Advantage plans.

Overall, Medicare Advantage enrollment in rural areas appears to be on the rise, and increasing at a faster rate than enrollment in metropolitan areas. Medicare beneficiaries in rural areas can choose from multiple plans and often multiple insurers in 2017. The growth in Medicare Advantage enrollment in rural areas deserves attention and monitoring, but at this point, its future growth trajectory appears to be similar to Medicare Advantage enrollment in other parts of the country, including metropolitan areas.

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- ¹⁰ Kronick, Richard, "Measuring Coding Intensity in the Medicare Advantage Program," Agency for Healthcare Research and Quality Views, October 2014; available at: <https://www.ahrq.gov/news/blog/ahrqviews/102014.html>
- ¹¹ Risk scores are the aggregate measure of a person's health status, as compiled by the Medicare Advantage HCC risk adjustment system
- ¹² Kronick, Richard and W. Pete Welch, "Measuring Coding Intensity in the Medicare Advantage Program," *Medicare & Medicaid Research Review*, 2014, volume 4, number 2; available at: https://www.cms.gov/mmrr/Articles/A2014/MMRR2014_004_02_a06.html
- ¹³ Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy," March 2017; available at: http://www.medpac.gov/docs/default-source/reports/mar17_medpac_ch13.pdf
- ¹⁴ Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy," March 2017; available at: http://www.medpac.gov/docs/default-source/reports/mar17_medpac_ch13.pdf
- ¹⁵ Kronick, Richard and W. Pete Welch, "Measuring Coding Intensity in the Medicare Advantage Program," *Medicare & Medicaid Research Review*, 2014, volume 4, number 2; available at: https://www.cms.gov/mmrr/Articles/A2014/MMRR2014_004_02_a06.html
- ¹⁶ Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy," March 2017; available at: http://www.medpac.gov/docs/default-source/reports/mar17_medpac_ch13.pdf
- ¹⁷ Several ongoing cases allege that insurers fraudulently increased HCC scores for Medicare Advantage enrollees. For example, the Department of Justice has joined a whistleblower lawsuit against UnitedHealth Group, accusing the insurer of intentionally coding plan enrollees as sicker in order to increase capitated payments from the Medicare program. Other insurers have settled lawsuits alleging that they submitted false claims on behalf of Medicare Advantage enrollees and exaggerated the severity of enrollees' health conditions; see Schulte, Fred, "Medicare Advantage Insurers Settle Whistleblower Suit For \$32 Million," NPR News, May 31, 2017, available at: <http://www.npr.org/sections/health-shots/2017/05/31/530868367/medicare-advantage-insurers-settle-whistleblower-suit-for-32-million>
- ¹⁸ Kronick, Richard, "Projected Coding Intensity In Medicare Advantage Could Increase Medicare Spending By \$200 Billion Over Ten Years," *Health Affairs*, February 2017, volume 36, number 2, pages 320-327.
- ¹⁹ <http://www.kff.org/medicare/issue-brief/medicare-advantage-2017-spotlight-enrollment-market-update/>

²⁰ As a point of comparison, in the Affordable Care Act health insurance marketplaces, metropolitan areas have 2.5 insurers participating, on average, and non-metropolitan areas have 2.0 insurers participating, on average, in 2017. See Semanskee, Ashley and Cynthia Cox, "Insurer Participation on ACA Marketplaces, 2014-2017," Kaiser Family Foundation, June 2017; available at: <http://www.kff.org/health-reform/issue-brief/insurer-participation-on-aca-marketplaces-2014-2017/>

²¹ Jacobson, Gretchen, Anthony Damico, Tricia Neuman, and Marsha Gold, "Medicare Advantage Plans in 2017: Short-term Outlook is Stable," Kaiser Family Foundation, December 2016; available at: <http://www.kff.org/medicare/issue-brief/medicare-advantage-plans-in-2017-short-term-outlook-is-stable/>. As a point of comparison, in the Affordable Care Act health insurance marketplaces, 38 counties (including 33 non-metropolitan counties) were at risk of having no insurers as of June 26, 2017, and 21 percent of marketplace enrollees have access to just one insurer on the marketplace. See Semanskee, Ashley and Cynthia Cox, "Insurer Participation on ACA Marketplaces, 2014-2017," Kaiser Family Foundation, June 2017; available at: <http://www.kff.org/health-reform/issue-brief/insurer-participation-on-aca-marketplaces-2014-2017/>

²² Jacobson, Gretchen, Anthony Damico, Tricia Neuman, and Marsha Gold, "Medicare Advantage 2017 Spotlight: Enrollment Market Update," Kaiser Family Foundation, June 2017; available at: <http://www.kff.org/medicare/issue-brief/medicare-advantage-2017-spotlight-enrollment-market-update/>

**Questions for the Record for Cheryl Wilson, RN, MA, LNHA
Ways and Means Health Subcommittee Hearing on
“Promoting Integrated and Coordinated Care for Medicare Beneficiaries”**

Subcommittee on Health (Minority):

Question: *What other populations could be helped by the PACE model?*

The PACE model of care currently serves high-cost, high-need populations 55 years of age and older, certified eligible for nursing home level of care, able to live safely in the community at the time of enrollment, with the appropriate services and supports provided by the PACE program.

As a comprehensive, fully integrated, provider-led, community-based care model, PACE is well positioned to serve other vulnerable populations who have complex medical care and functional support needs with the intensive care coordination that is required. These populations include, but are not limited to:

- Individuals under age 55 with a physical, intellectual or developmental, cognitive or behavioral health related disability who are certified by the state to need a nursing home level of care;
- Individuals with complex medical conditions and functional disabilities who may not yet be nursing home eligible but are at significant risk for becoming so.

In fact, the National PACE Association and its membership have explored this question extensively and produced two documents that address this topic in great detail: the Adapted PACE Protocol and the At-Risk Medically Complex Framework. I am hopeful, as is NPA, that the Centers for Medicare and Medicaid Services will move quickly to implement the PACE pilots authorized by the PACE Innovation Act of 2015 (**P.L. 114-85**) to further explore how the PACE model can effectively meet the needs of these populations.

Question: *How do PACE organizations integrate medical and social components of health care?*

Integration of the medical and social components of health care is a fundamental characteristic of the PACE model and crucial to its ability to maximize PACE participants' health status, quality of life and independence at home and in the community.

In PACE, integration and coordination of all aspects of care occur at the provider level, fundamentally changing how care is provided relative to the fee-for-service system and insurer-based plans. Upon enrollment in PACE, participants and their caregivers work with an interdisciplinary team (IDT) made up of physicians and nurse practitioners, nurses, therapists, social workers, dietitians, personal care aides, transportation drivers and many others. IDT members perform assessments to determine each participants' needs and, working with each participant and their family/ caregivers as appropriate, develop comprehensive, person-centered care plans to respond to these needs across all care and social settings 24 hours a day,

seven days a week, 365 days a year. Services and supports provided by PACE include primary and specialty medical care; prescription drugs; specialty care such as audiology, dentistry, optometry, podiatry and speech therapy; respite care; transportation; adult day services, including nursing, meals, nutritional counseling, social work; in-home services; personal care; supportive services, home renovations, physical, occupational and recreational therapies; and hospital and nursing home care, when necessary.

PACE participants receive these services in the most appropriate setting — home, the PACE Center, or in the community as directed and coordinated through the Inter Disciplinary team (IDT). In the home, PACE offers skilled care, assistance with activities of daily living, personal care supportive services, home cleaning, meals, laundry, and supports such as ramps, grab bars, and other tools that facilitate participant safety and independence.

At the PACE center, participants receive primary care, therapy, meals, recreation, socialization and personal care. In the community, PACE ensures participants' access to specialists and other providers. Importantly, PACE IDT members deliver most of the care directly, enabling them to personally monitor participants' health on a frequent basis, often daily, and responding rapidly with any necessary changes to the care. This is critical for individuals enrolled in PACE whose chronic conditions can quickly deteriorate if not closely monitored.

Furthermore, because PACE organizations are fully responsible for the quality and cost of all care provided, they have a financial incentive to provide all necessary care and services that maintain the highest level of health and independence. The PACE IDT is also responsible for directing, managing and paying for services delivered by contracted providers such as hospitals, nursing homes, specialists and community support services.

Question: *Please provide a summary of the geographic areas that currently have a PACE program? Number of PACE programs in urban settings? Number of PACE programs in rural settings?*

As of January 1, 2017, there are 122 sponsoring PACE organizations operating 239 centers in 31 states; a list of PACE organizations is attached for your information. Regarding the numbers of PACE programs in urban and rural settings, 103 serve urban areas, while 19 serve rural localities. The following programs are categorized by the National PACE Association as rural given their service areas: AILCARE for Seniors, Cedar Bluff, VA; Centra PACE, Lynchburg, VA; Cherokee Elder Care, Tahlequah, OK; LIFE Geisinger, Danville, PA; Mercy Life of Alabama, Mobile, AL; Midland Care PACE, Topeka, KS; Mountain Empire PACE, Big Stone Gap, VA; Northland PACE, Bismarck, ND; PACE at Home, Newton, NC; Piedmont Health SeniorCare, Pittsboro, NC; Redwood Coast PACE, Eureka, CA; Senior CommUnity Care of Colorado, Montrose, CO; Siouxland PACE, Sioux City, IA; SpiriTrust Life Lutheran, Chambersburg, PA; Stay Well Senior Health, Asheboro, NC; The Oaks PACE, Orangeburg, SC; Total Senior Care, Olean, NY; Total Life Health Care, Jonesboro, AR; Wyoming PACE, Cheyenne, WY.

Question: *How can policymakers support expansion of the PACE program?*

Policymakers can support expansion of the PACE program by enacting several legislative changes to eliminate existing barriers and facilitate increased access to this proven model of care for Medicare beneficiaries. The recommended changes include:

1. Allow Medicare-Only beneficiaries who enroll in PACE to choose a distinct Part D plan, rather than requiring them to enroll in the Part D plan of the PACE organization,
 2. Permit PACE organizations more flexibility in determining the premiums charged to Medicare-Only beneficiaries,
 3. Authorize PACE Organizations in states without PACE to move forward under a contract with Medicare.
 4. Promote the adoption of the new CMS PACE regulations
 5. Authorize PACE Pilot programs
- 1- PACE is required to provide all Medicare and Medicaid benefits to a participant. Therefore, a Medicare-only beneficiary is limited to the Part D plan offered by the PACE program for prescription drug coverage. Unlike dually-eligible beneficiaries, Medicare-only beneficiaries must pay a monthly premium for Part D coverage. As such, they should have the freedom to select the Part D plan of their choice. Greater selection and flexibility is critical so that Medicare beneficiaries may receive the Part D coverage best suited to their medical and financial needs.
 - 2- Existing regulations limit the ability of PACE organizations to establish the premiums charged to Medicare-only beneficiaries since the amounts must be set in accordance with the Medicaid rates paid for dual-eligible beneficiaries. This requirement unduly limits the ability of PACE organizations to set premiums accounting for differences in care needs existing among a nursing home-eligible population. With few exceptions, PACE Medicaid rates for dually-eligible individuals are not adjusted for risk or need.
 - 3- Currently, PACE organizations can operate only in states that have added the PACE program to their Medicaid plans and agree to enter into three-way PACE program agreements with PACE organizations, the State, and CMS. To date, 19 states have not elected PACE as a state option, so Medicare beneficiaries do not have access to the program in those states.
 - 4- PACE organizations face operational and administrative requirements that constrain growth. In its comments to CMS on the proposed PACE rule (**CMS-4168-P**), NPA has stressed the need for more flexibility to:
 - Allow PACE organizations, in addition to operating a PACE Center, the option to offer and oversee services in other settings (e.g., adult day health centers, senior centers) that support the interaction of PACE participants with one another and with PACE interdisciplinary team members;
 - Include community physicians as members of the PACE interdisciplinary team;
 - Utilize Nurse Practitioners and Physician Assistants as primary care providers; and

- Provide operational flexibility to configure the PACE interdisciplinary team based on the needs of individual participants.

The proposed rule was issued on August 16, 2016 and the comment period for the rule closed on October 17, 2016. It is critical that a final rule be issued by CMS so that PACE organizations may have the operational flexibility needed to grow and serve more frail seniors and those living with disabilities.

- 5- Policymakers can urge CMS to support PACE growth by implementing the pilot authority provided by Congress to allow PACE to serve new populations with similar needs and medical complexities to the population currently served.

On October 21, 2015, Congress passed the PACE Pilot Act with unanimous, bipartisan support. In response, on December 23, 2016, CMS released a request for information (RFI) to develop PACE pilots for new populations. Through the RFI, CMS requested information on the design and future implementation of a broad range of PACE pilots. The RFI provided the greatest detail regarding a five-year pilot (the Person Centered Community Care Model, P3C) for people with physical mobility impairments, while also seeking input on potential pilots for individuals with other needs, including but not limited to, people with intellectual and developmental disabilities, and individuals with complex medical and functional support needs who are at risk of needing a nursing home level of care. The comment period for the RFI closed on February 10, 2017. To date, CMS has not moved forward to incorporate those comments into an announcement of PACE pilots. We ask CMS to issue the PACE pilots in the near future.

Representative Higgins (D-NY):

Question: *The PACE program is vital to keeping many older citizens in my district and around the country safe in their homes and integrated into their communities. And the program has a demonstrated record of success.*

One PACE participant from West Seneca, New York in my district waited until her 55th birthday to get into the program. In the year before her enrollment in the program, she was admitted to the hospital eight times. Since being enrolled with a PACE program operated by Catholic Health nearly four years ago, she has been in the hospital only three times. This has greatly improved both her quality of life while significantly reducing costs to the system. The patient does not have to go out to several specialists, even though she has multiple illnesses, because her medical needs are managed at PACE. When she requires specialty care it is coordinated along with the necessary transportation and additional wraparound supports. She thrives in this program because it addresses her medical, social, psychosocial needs and because all of those needs are coordinated and managed under one umbrella.

Knowing the success of PACE, I am very concerned about how proposed funding cuts in both the President's proposed budget for Fiscal Year 2018 and the House-passed American Health Care Act could impact participants of PACE, nearly all of whom are some of the most vulnerable dual

eligibles, I am also interested in hearing your thoughts on what works and what could be improved in the PACE space.

As a professional with a long record of experience with PACE program and the beneficiaries participating in it, how do you think the proposed cuts to Medicaid under the President's budget and the American Health Care Act will affect PACE?

Improvements to the PACE space will be addressed with the passage of the CMS new regulations and the implementation of the PACE Pilot programs passed by Congress October 21, 2015 as noted above.

Additionally, if states with no PACE programs currently authorized were encouraged to bring this amazing program to ensure care for their very vulnerable seniors, costs would be reduced, independence and health improved, with improved quality of life for family caregivers.

To preserve the Medicaid program's ability to support PACE for frail seniors, I respectfully request that you ensure funding is maintained to a level that will sustain services for high need, high cost individuals. It is imperative that the Medicaid safety net for our nation's most vulnerable remains strong. If state Medicaid funding is significantly reduced, PACE organizations should be recognized as a vital, cost effective provider of care to a vulnerable population, and reimbursement should be continued as is.

I am concerned about the possible impact of Medicaid cuts on PACE because strained state budgets continue to be challenged in adequately caring for those with the highest needs and highest costs. Specifically, the ability of state Medicaid programs to sustain the multifaceted services provided to frail seniors by my PACE (Program of All-Inclusive Care for the Elderly) organization could be severely constrained. The option may be for additional funding through the Medicare program for these elderly persons.

PACE participants require a nursing home level of care, however, 95 percent live in the community and receive all their preventive, primary, acute, long term and personal care services through their local PACE program. Ninety percent of these participants are dual eligible. PACE participants receive their services through a capitated cost that is, on average, 16.5 percent less per person, per month, than the costs state Medicaid programs would otherwise incur to care for these individuals. Under the AHCA's proposed per capita funding model, federal support of the Medicaid program may not recognize the higher needs of PACE participants, or the importance of the social determinants of health care embraced in PACE. Consequently, state Medicaid programs may conclude that budgets are insufficient to sustain PACE as a viable program, especially as PACE is an "optional" service.

[Submissions for the Record follow:]



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John Lovelace, Chairman | Margaret A. Murray, Chief Executive Officer

**ACAP Statement on Medicare Advantage Hearing on Promoting Integrated and Coordinated
Care for Medicare Beneficiaries**

House Ways and Means Health Subcommittee
June 6, 2017

Chairman Tiberi, Ranking Member Levin, Members of the Health Subcommittee:

Thank you for holding this important hearing on promoting integrated and coordinated care for Medicare beneficiaries. The Association for Community Affiliated Plans (ACAP) represents 60 safety net health plans serving more than 20 million Americans in 29 states. Of those, 25 health plans in 15 states participate as Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs), 23 plans operate Managed Long-term Supports and Services (MLTSS) plans, and 14 plans operate Medicare-Medicaid Plans (MMPs) in the Financial Alignment Demonstration and collectively enroll over 30 percent of all MMP enrollees.

ACAP is strongly supportive of promoting integrated and coordinated care models for Medicare and Medicaid beneficiaries, also known as “dual eligibles.” The dual eligible population is particularly well served by participating in a system of care that addresses the health care needs of enrollees in an interdisciplinary manner. Integrated care poses the best opportunities to control health care costs, improve health outcomes, and get beneficiaries the services they need.

As Congress considers the D-SNP program, ACAP strongly supports a number of changes to this program. The most important issue is the need to create certainty that D-SNPs have a future and that states, beneficiaries, providers, and plans can count on their existence in the future. Since their creation in 2003, the D-SNP program has been subjected to numerous short-term authorizations that, we believe, have slowed state commitment to truly integrating D-SNPs into a broader strategy to address the health care needs of dual-eligible beneficiaries. ACAP strongly supports permanent authorization of D-SNPs and urges Congress to do so as part of the discussions over Medicare extenders this year. We have attached a letter supported by six national organizations, including ACAP, representing businesses, unions, health care providers, health plans, and consumers urging Congress to permanently authorize the Medicare Advantage D-SNP program this year.

In addition to creating the program certainty and stability that permanent authorization would provide, ACAP supports additional changes to the D-SNP program. Specifically, ACAP supports the following changes in the underlying law:

- Direct the Secretary of HHS to develop a long-term solution to accurately measure quality for dual eligibles and D-SNPs through the Star Ratings program. As the Office of the Assistant Secretary for Planning and Evaluation (ASPE) recently found, “dual status” results in lower scores on quality measures due to



socioeconomic status. The Star Ratings program currently does not account for socioeconomic status, resulting in incorrect quality scores for D-SNPs.

- Create a unified appeals and grievances process between Medicare and Medicaid for dual-eligible beneficiaries.
- Direct the CMS Medicare-Medicaid Coordination Office (MMCO) as the point of contact for D-SNPs in addition to MMPs and give MMCO more authority to develop alignments between Medicare and Medicaid.
- Apply the CMS-HCC frailty adjuster to all Medicare beneficiaries receiving long-term care services and supports, both in institutions and in the community. Currently, only Fully Integrated Dual-eligible Special Needs Plans and PACE providers can receive the frailty adjuster. As a result, payments to D-SNPs and other MA plans do not account for the high medical costs associated with frailty.

The Association for Community Affiliated Plans believes that the Medicare Advantage D-SNP program as well as the MMP demonstrations, are vital structural supports for helping to address the health care needs of aged, blind, and disabled Americans that rely on receiving Medicare and Medicaid benefits in a coordinated care setting. We look forward to working with you to assure that integrated and coordinated care services continue to be a core and vital option for dual eligibles.

Margaret A. Murray
Chief Executive Officer

June 6, 2017

The Honorable Paul Ryan
Speaker U.S. House of Representatives
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Washington, DC 20515

The Honorable Kevin Brady
Chairman, Ways and Means Committee
United States House of Representatives
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The Honorable Richard Neal
Ranking Member, Ways and Means Committee
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The Honorable Nancy Pelosi
Democratic Leader, U.S. House of Representatives
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The Honorable Greg Walden
Chairman, Energy and Commerce Committee
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The Honorable Frank Pallone
Ranking Member, Energy and Commerce Committee
United States House of Representatives
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Speaker Ryan, Leader Pelosi, Chairmen Brady and Walden, and Representatives Neal and Pallone:

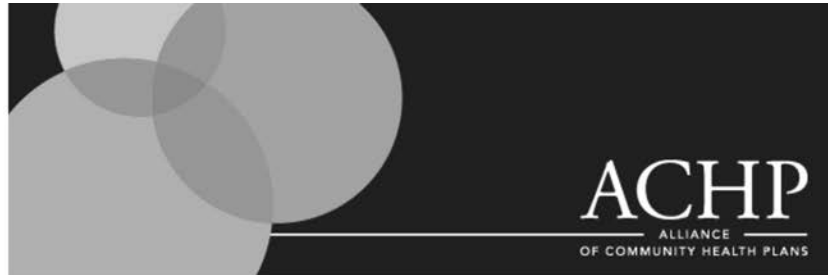
We, the undersigned organizations representing Medicare Advantage Dual-eligible Special Needs Plans, health care providers, and advocates, are writing to urge Congress to permanently authorize the Medicare Advantage Dual-Eligible Special Needs Plan (D-SNP) program this year. D-SNPs play an important role in delivering and coordinating Medicare and Medicaid benefits for dual-eligible beneficiaries and tailor care management, provider interventions, and partnerships with community-based organizations to the unique needs of their dual-eligible enrollees. We believe that this program, in existence for over a decade, has demonstrated its vital role in serving the dual-eligible population. Congress should finally give this program the long-term stability that states, plans, and beneficiaries need.

As you know, D-SNPs have been reauthorized several times with bipartisan support, but through a series of short-term extensions. As it stands, the program's authorization expires at the end of 2018. Full integration of Medicare and Medicaid benefits through the D-SNPs' contracts with states or between D-SNPs and managed long-term care services and supports (MLTSS) plans requires intensive work and collaboration spanned across multiple years. Short-term reauthorizations impede states and plans from entering longer-term partnerships and making investments in integration by creating uncertainty and questions surrounding Congress' support of the program. To provide stability for states, plans, and the nearly 2 million Medicare beneficiaries enrolled in D-SNPs, we believe that Congress should, in the best case, permanently authorize D-SNPs or, at a minimum provide a long-term reauthorization of no less than seven years.

Medicare/Medicaid Dual Eligibles are among the most-costly and hardest-to-serve populations receiving benefits in either program and we believe that the D-SNP program offers great opportunity and potential to improve care and benefits coordination and quality of care. It is widely believed that the reauthorization of the D-SNP program will accompany other Medicare extenders legislation and we strongly urge this bipartisan program to accompany this or other priority legislation moving through the House as soon as possible. The Senate Finance Committee has already signaled its unanimous and bipartisan support for permanent reauthorization and we urge the House to do the same. That is why we are urging you, as bipartisan leaders in the House of Representatives, to move legislation permanently authorizing D-SNPs this year.

In advance, thank you for your consideration of this request.

Alliance of Community Health Plans
America's Health Insurance Plans
Association for Community Affiliated Plans
Better Medicare Alliance
National Coalition on Health Care
The SNP Alliance



**Statement of the
Alliance of Community Health Plans
for the Record**

**U.S. House of Representatives
Committee on Ways and Means
Subcommittee on Health**

**Re: Medicare Advantage Hearing on Promoting Integrated and
Coordinated Care for Medicare Beneficiaries**

June 7, 2017

MAKING HEALTH CARE BETTER

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Statement of the
Alliance of Community Health Plans
for the Record

U.S. House of Representatives
Committee on Ways and Means
Subcommittee on Health

Re: **Medicare Advantage Hearing on Promoting Integrated and
Coordinated Care for Medicare Beneficiaries**
June 7, 2017

The Alliance of Community Health Plans (ACHP) appreciates the importance which the Committee places on the Medicare Advantage (MA) program and its attention to the challenge of improving the integration and coordination of care in MA, particularly for those Americans with chronic conditions. ACHP's non-profit, community-based plans partner with the government to provide MA coverage at the highest quality levels, consistently achieving 4- and 5-star ratings.

ACHP brings together innovative health plans and provider groups leading the nation towards a value-based health care and integrated delivery system. Our members are integrated, provider-aligned health plans providing coverage and care for more than 18 million Americans across 27 states and the District of Columbia, including 2.4 million Medicare beneficiaries.

We hope that the Committee will act on legislation that encourages innovative and cost effective approaches to caring for Americans receiving Medicare benefits, with the goal of improving health outcomes. Among the significant issues requiring attention are reauthorization of Special Needs Plans (SNPs), expansion of telehealth in Medicare Advantage, restoring quality payments under the MA benchmark cap, and flexibility to offer coverage using Value-Based Insurance Design (VBID).

Special Needs Plans

Given their long record of serving more than two million of the most vulnerable Medicare beneficiaries, ACHP encourages the committee to permanently reauthorize Special Needs Plans. Congress has consistently recognized the value of SNPs, as it has regularly extended the program over the past 14 years. We hope that the Committee will provide the more than 500 SNPs operating nationwide, including SNPs offered by ACHP member plans to tens of thousands of Medicare enrollees, the assurance that they can continue to serve Americans with chronic conditions, disabilities and other special needs without the fear that the program will be terminated.

The individualized nature of SNP coverage means that beneficiaries enrolling in the program receive better tailored and more coordinated services than they might otherwise have access to in fee-for-service Medicare or the broader Medicare Advantage program. Coverage and care under the SNP program can be further enhanced with new provisions, such as those in legislation reported by the Senate Finance Committee, that promote integration of services but also recognize that states may not take the same approach, or move at the same pace, to fully integrate regulatory, financial, and delivery system structures between Medicare and Medicaid.

Permanent authority for SNPs will encourage both states and health plans to devote necessary resources to special populations served by the program and move further towards integrated approaches and

innovative delivery designs – steps ACHP's plans have taken for years. ACHP urges Congress to provide such authority.

Telehealth

The Committee can take important steps to modernize Medicare by allowing Medicare Advantage plans to offer clinically appropriate, telehealth benefits in their annual bid amounts beyond the services that currently receive payment under Part B. ACHP members increasingly utilize remote access technologies to provide clinical care and strengthen coordination of services across settings – the latter an especially important aspect of caring for chronically ill seniors or enrollees in rural and difficult to reach areas. These efforts are enhanced by our members' reliance on electronic medical records.

Initial evidence from ACHP member plans indicates that the use of telehealth does not increase costs and may, in fact, lower them. For example, in its [testimony](#) to the Senate Finance Committee on May 16, 2017, UPMC Health Plan states that a 2014 analysis of its e-visit program, "Anywhere Care," found no evidence that e-visits or other telehealth initiatives added to costs. In fact, "data indicated that members who utilized an e-visit had a lower overall cost of care for the conditions treated than members who sought the same care in an emergency room, urgent care center, primary care office, or retail clinic."

While CMS has modestly expanded use of telehealth-based services as supplemental benefits through administrative action, that approach limits expansion of effective and efficient technologies. **ACHP urges the committee to enact legislation authorizing services provided by remote access technologies to be considered covered services under basic benefits and therefore part of the MA bid.** Medicare leadership and support for innovative clinical approaches relying on remote access technologies would have a substantial impact on the entire delivery system.

If the Committee moves forward on the telehealth issue, we hope that statutory language will not be unnecessarily limiting, given the pace of technological change. An approach that is overly prescriptive in listing specific services that are permitted and not permitted, or directing the Secretary to develop such a list, is not likely to keep up with changing technology and innovations that improve care and patient access.

Medicare Advantage Benchmark Cap

ACHP urges the Committee to pass H.R. 908, the *Medicare Advantage Quality Payment Relief Act of 2017*, introduced by Representatives Mike Kelly and Ron Kind. Their bipartisan legislation would finally correct the substantial losses affecting 2.5 million seniors due to the so-called "benchmark cap" that has reduced or eliminated quality incentive payments in Medicare Advantage. The unintended consequence of the benchmark cap provision has been to undermine value-based care and diminish benefits to seniors worth tens of millions of dollars.

The Centers for Medicare and Medicaid Services (CMS) under the previous administration interpreted Medicare law in a way that is contrary to Congressional intent, denying Medicare benefits to seniors who enrolled in high quality plans specifically so they could take advantage of enhanced benefits. CMS' decision has reduced or eliminated quality payments to plans in about half the nation's counties. In some areas, 4- and 5-star MA plans may receive the same payment as a 3-star plan, contrary to Congress' goal of paying for quality. According to MedPAC's [March 2016 Report to Congress](#), the cap reduces county benchmarks by an average of \$480 annually – and that figure will be higher for 2018. The benchmark cap interpretation has also limited the effects of CMS' laudable initiative to account for the effects of high

enrollment of dual eligible beneficiaries on star ratings; even if they achieve a 4-star rating, plans with high numbers of dual eligibles will not receive a quality incentive payment in capped counties.

While we have argued, with supporting legal analysis, that CMS has discretionary authority to resolve this problem, to date the counsel's office has reaffirmed the agency's interpretation. The clearest solution would be statutory language that leaves the benchmark cap in place – *we do not advocate elimination of the cap* – but directs the Secretary to exclude the quality payments from the benchmark cap calculation, similarly to how quality payments are made in other areas of Medicare. Fixing this problem will provide seniors with enhanced care as any savings gleaned by MA plans, by statute, must be returned to seniors in the form of reduced premiums or cost-sharing and enhanced benefits.

Value-Based Insurance Design

ACHP encourages the Committee to enact provisions granting Medicare Advantage plans flexibility to establish benefit structures that vary based on chronic conditions of individual enrollees. Similar value-based insurance designs (VBID) have been used in the commercial market with promising results.

We believe that MA plans should be allowed to develop, and beneficiaries to choose, coverage options designed specifically to improve care for their chronic conditions and prevent further progression of the disease. Value-based designs would allow MA plans to offer enhanced benefits, reduce cost-sharing for effective services, adjust provider networks to promote treatment by high quality and efficient providers, and offer care improvement and wellness programs tailored to specific chronic conditions.

ACHP believes there are several principles that should be considered in developing legislation that will expand use of VBID in managing chronic conditions while preserving options for, and protecting the interests of, all beneficiaries. These include:

- *Beneficiary engagement and protections:* Active and informed beneficiary engagement is critical to the success of VBID. For example, beneficiary participation in health risk assessments and shared decision-making will help plans better understand the needs of the patient, and the patient will have a more informed understanding of evidence-based practices to manage his or her conditions.
- *Benefit design based on clinical information:* Value-based design to meet the needs of chronically ill MA enrollees moves away from Medicare's "one size fits all" approach under which cost sharing for certain services must be uniform across beneficiaries. Criteria will be necessary to assure that there is sound clinical evidence and demonstration of provider quality for promoting certain services and providers. Criteria based on clinical information are also important in discouraging use of services and providers considered to be less effective and efficient in treating patients with chronic conditions. An appropriate exceptions process should be included as a further beneficiary protection.
- *Careful measurement and evaluation:* Expansion of VBID will require metrics to carefully assess beneficiary understanding, access, quality, and service of tailored benefit structures.

We appreciate the Committee's commitment to improve the Medicare Advantage program. MA plans have become a valued choice for beneficiaries. The steady rise in the percentage of seniors choosing an MA plan year after year is evidence these plans offer attractive, affordable, high quality benefits. ACHP member plans welcome the opportunity to work with you and members of both parties to develop market-tested solutions based on many years of experience improving the health of communities across the nation and the American health care system as a whole.



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**Statement
of the
American Hospital Association
before the
Committee on Ways and Means
of the
U.S. House of Representatives**

**“Medicare Advantage Hearing on Promoting Integrated and Coordinated Care for
Medicare Beneficiaries”**

June 7, 2017

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations (approximately 100 of which sponsor health plans), and our 43,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to submit for the record our comments on the importance of promoting integrated and coordinated care for Medicare beneficiaries served through the Medicare Advantage (MA) program.

The MA program is an important source of coverage for approximately a third of Medicare beneficiaries. More than 60 AHA members sponsor MA plans, and nearly all AHA members contract with such plans to provide services to enrolled Medicare beneficiaries.

The MA program is a success when measured on metrics such as marketplace competition, consumer satisfaction and quality of care. However, there are a number of areas where the program can be improved as part of continuous efforts to advance health care quality, health outcomes and health system efficiency, particularly through better integration and coordination of care.

**RECOMMENDED APPROACHES TO IMPROVING INTEGRATED AND COORDINATED CARE FOR
MEDICARE BENEFICIARIES**

Below are several priority recommendations for improving the integration and coordination of care for beneficiaries enrolled in the MA program. The Committee specifically sought input on the role of Special Needs Plans (SNPs), which we address in our first recommendation below.



We also propose several changes to the MA program that would apply to all models of MA plans, not just SNPs. Finally, the Committee expressed interest in recommendations for improving the Program of All-Inclusive Care for the Elderly (PACE). We do not include specific recommendations for Congressional action here but rather point the Committee to comments the AHA submitted to the Centers for Medicare & Medicaid Services (CMS) related to the [PACE Innovation Act](#) and a [2016 proposed rule](#), and we encourage Congress to work with the agency to pursue their implementation.

- **Providing Continued Access to MA Special Needs Plans (SNPs) for Vulnerable Populations.** SNPs offer certain Medicare beneficiaries more tailored benefit plans to address their special needs. Currently, the SNP program is set to expire on December 31, 2018. **We encourage Congress to extend or make permanent the SNP program while incorporating program reforms consistent with the other recommendations that follow, particularly related to the ability to further tailor benefit packages based on individual need.**
- **Adapting Benefits to Meet the Needs of MA Enrollees.** In most instances, insurers must provide all plan enrollees with the same set and scope of benefits. We recognize that such a policy is intended to prevent discrimination and ensure access to care for all enrollees. However, this requirement has the negative consequence of preventing plans from addressing the unique needs of some enrollees. In some cases, a small subset of enrollees would benefit from a certain specialized service, but plans are unable to offer it due to the resources required to make such a service available to everyone. **We encourage Congress to give plans the flexibility to tailor their products to better meet the needs of subsets of enrollees, such as by expanding the concept of value-based insurance design nationally.** Consistent with existing oversight mechanisms, CMS could continue to monitor that all beneficiaries are receiving the care that they need and that such policies are not unintentionally resulting in adverse outcomes.
- **Increasing Quality of Care and Convenience for MA Enrollees through Telehealth.** Innovation in technology has the potential to increase Medicare beneficiaries' timely access to services, which may increase the quality of care, improve patient satisfaction and reduce costs for the health care system. **Congress should pursue all avenues to expand access to services via telehealth, including removing barriers caused by the geographic location and practice setting "originating site" requirements and restrictions on covered services and technologies. MA plans also should be permitted to submit costs associated with telehealth as part of their bid amounts.**
- **Permitting for Holistic Care through Coverage of Certain Social Services.** Many social, economic and demographic factors contribute to an individual's health status, such as secure and safe housing, employment status, support system to assist with activities of daily living, and adequate nutrition. These factors often cannot be addressed by medical services alone, yet may be the primary drivers of health status and outcomes, as well as health care utilization and total spending by Medicare and other payers. MA plans currently have limited options for providing non-medical social services to help address these underlying social determinants of health. **We encourage Congress to allow plans**

to offer non-medical social services and include the costs associated with these services in their bid amounts.

As part of this, we strongly encourage Congress to allow plans to provide services that facilitate keeping individuals in their homes. Two examples include personal care services for beneficiaries who do not have a need for skilled care and remote patient monitoring. Such services have a number of benefits: patients typically prefer staying in their homes, the home can be the most efficient site of care, and providers can often detect new or deteriorating conditions earlier in the disease progression, thus resulting in more efficient use of health care resources and better outcomes.

- **Ensuring Accurate Payment. The AHA strongly urges Congress to direct CMS to refine the Hierarchical Condition Categories (HCC) risk-adjustment model to further account for socioeconomic and demographic status.** We applaud CMS for recent changes to the HCC risk adjustment model that better account for socioeconomic status by considering whether an individual is a full or partial Medicare/Medicaid dual-eligible. However, these changes do not go far enough. There is a strong and growing body of evidence that a number of patient characteristics impact health outcomes, health care utilization and cost of care. The National Academies of Medicine recently identified five social – not medical – factors that influence access to care, health care use, health outcomes and cost:
 - 1) socioeconomic position;
 - 2) race, ethnicity and cultural context;
 - 3) gender;
 - 4) social relationships; and
 - 5) residential and community context.¹

These factors are not fully accounted for in the HCC risk-adjustment model and should be considered for future adjustments. Better accounting of sociodemographic information, where appropriate, will ensure that plans are adequately reimbursed for more complex patients. Failing to account for these factors when establishing reimbursement rates can harm patients and worsen health care disparities by diverting resources away from plans serving large proportions of disadvantaged patients and their network providers.

- **Providing MA Enrollees with Hospice Benefits. The AHA supports the integration of hospice services into the MA benefit package.** Today, hospice benefits for MA enrollees are coordinated and delivered through the fee-for-service Medicare program while other covered, but “unrelated,” services are managed separately by the MA plan. Integrating these two care coordination streams may enhance the quality and efficiency of care, as well as the patient and family experience.

¹National Academies of Sciences, Engineering, and Medicine. 2016. Accounting for Social Risk Factors in Medicare Payment: Identifying Social Risk Factors. Washington, DC: The National Academies Press.
<https://doi.org/10.17226/21858>

In pursuing this change, however, adequate beneficiary safeguards must be put in place. Plan rates will need to be adjusted to incorporate costs associated with the hospice benefit. Additionally, nothing in the integration of these services or in the development of the plan rates should disrupt or dismantle the important interdisciplinary structure of hospice services, which includes social work, chaplaincy and family bereavement services in addition to the management of pain and other symptoms. Moreover, given the unique nature of this benefit, plans should be required to implement instant coverage determinations and expedited appeals processes for coverage denials.

CONCLUSION

We appreciate the opportunity to provide these comments and support the Committee's efforts and attention to examining the issues concerning the quality and efficiency of care delivery to Medicare beneficiaries. We remain deeply committed to working with Congress, the Administration, Medicare beneficiaries and other health care stakeholders to ensure a high-performing MA program for the millions of seniors who rely on the program today and in the years to come.



STATEMENT FOR THE RECORD

**Submitted to the
House Ways and Means Committee
Subcommittee on Health**

*Medicare Advantage:
Promoting Integrated and Coordinated Care for Medicare Beneficiaries
June 7, 2017*

America's Health Insurance Plans
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America's Health Insurance Plans (AHIP) is the national association whose members provide coverage for health care and related services to millions of Americans every day. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access and well-being for consumers.

We thank the committee for strongly supporting the Medicare Advantage (MA) program. Many committee members – both Republicans and Democrats – signed letters earlier this year, urging the Centers for Medicare & Medicaid Services (CMS) to avoid further MA payment cuts and maintain stable coverage options for beneficiaries in the 2018 rate setting process. Overall, more than 320 members of Congress addressed letters to CMS, expressing support for the MA program, in the weeks leading up to the April 3 announcement of 2018 MA payment rates.

The reason for this strong, bipartisan support is simple: the MA program is providing better value, better services, and better health. Medicare Advantage delivers real results for the people who depend on the program – and for the hardworking taxpayers who support it.

When MA plans work with providers to deliver more coordinated care, we make meaningful progress to deliver better care, improved health, and lower costs for all patients – not just those in Medicare Advantage.

According to recent research, in areas where penetration is strongest, the MA program has had a “spillover effect” in delivering significant decreases in Medicare fee-for-service (FFS) spending growth. Researchers in *Health Affairs* found that in counties with high baseline MA penetration rates, each 10 percentage point increase in MA penetration was associated with a decrease in per patient FFS spending of \$154 annually.¹

For years, MA bids have been lower than the FFS program on average for delivering basic Medicare benefits. Today, the MA program is more efficient than traditional Medicare at delivering benefits and care to seniors and individuals with disabilities.

¹ Johnson, Garret, Figuero, Jose F., Zhou, Xiner, Orav, E. John, Jha, Ashish K. Recent growth in Medicare Advantage enrollment associated with decreased fee-for-service spending in certain US counties. *Health Affairs* 35(9):1707-1715. September 2016.

These results show the critical role of the private sector and government working together – efficiently and effectively. They show that proven approaches – like coordinated care and a focus on wellness and prevention – deliver real value and are essential to success.

We appreciate that today’s hearing focuses on the role played by the MA program in promoting integrated and coordinated care for seniors and individuals with disabilities. Through their participation in the MA program, our members have a long track record in emphasizing prevention, providing access to disease management services for chronic conditions, implementing value-based care, and offering systems of coordinated care for ensuring that beneficiaries receive the health care services they need.

Our members also have demonstrated strong leadership in sponsoring MA Special Needs Plans (SNPs) that serve as a crucial safety net for approximately 2.4 million of our nation’s most vulnerable seniors. As participants in the SNP program, our members tailor their benefits and services to address the unique needs of individuals who are dually eligible for both Medicare and Medicaid, who have severe or disabling chronic conditions, or who qualify for an institutional level of care.

Medicare-Medicaid Demonstration Plans (MMPs) are another promising model for providing coordinated, integrated health care to vulnerable beneficiaries. These plans currently serve more than 397,000 enrollees in a number of states as part of an initiative to better align the financing of Medicare and Medicaid and to integrate primary care, acute care, behavioral health, and long-term services and supports for dual eligible enrollees.

Programs of All-Inclusive Care for the Elderly (PACE) provide an important option for more than 38,000 older adults and people age 55 and over living with disabilities. PACE organizations provide medical, social, and long-term care services – through a managed care model – to frail, community-dwelling individuals who are eligible for nursing home-level care according to state Medicaid standards. As the elderly population in our country increases, PACE programs can become an increasingly important model of care delivery.

Our statement focuses on two topics: (1) our members’ strong commitment to serving Medicare beneficiaries; and (2) legislative recommendations for expanding on the MA program’s success in delivering coordinated care to Medicare beneficiaries.

Our Members' Commitment to Serving Medicare Beneficiaries

AHIP's members are strongly committed to serving Medicare beneficiaries under the MA program and continuing to provide coverage for cost-effective, high quality, and accessible health care.

MA plans offer a different approach to health care delivery than beneficiaries experience under the Medicare FFS program. MA plans have developed systems of coordinated care for ensuring that beneficiaries receive health care services on a timely basis, while also providing access to disease management services for their chronic conditions. These coordinated care systems provide for the seamless delivery of health care services across the continuum of care. Physician services, hospital care, prescription drugs, and other health care services are integrated and delivered through an organized system whose overriding purpose is to prevent illness, manage chronic conditions, improve health status, and employ best practices to swiftly treat medical conditions as they occur, rather than waiting until they have advanced to a more serious stage. MA plans also help to reduce emergency room visits for routine care, ensure prompt access to primary care physicians and specialists when care is needed, and promote communication among treating physicians about the various treatments and medications a patient needs.

As part of their overall strategy for serving Medicare beneficiaries, MA plans also are implementing patient-centered innovations that include:

- Mitigating the harm of chronic diseases by focusing on prevention, early detection, and care management;
- Reducing beneficiary costs;
- Addressing the needs of vulnerable individuals, including low-income beneficiaries; and
- Applying clinical best practices to increase patient safety and limit unnecessary utilization of services.

Today more than 18.6 million Americans – about 32 percent of all Medicare beneficiaries – have chosen to enroll in the MA program, and 16.7 million of them receive drug benefits through their

plan.² Since 2010, MA enrollment has increased by 60 percent. While the average payment to MA plans is equivalent to FFS costs, MA bids are 10 percent below FFS costs and MA plans often offer additional benefits to enrollees for no additional premium. Ninety percent of beneficiaries can choose from at least five MA plans.

Research findings consistently demonstrate that the innovative strategies adopted by MA plans translate into better health outcomes for enrollees. For example:

- In January 2017, *Health Affairs* published a study showing that utilization of post-acute care following a hospital discharge was lower for MA enrollees than for FFS enrollees. The authors of this study stated: “Medicare Advantage patients also exhibited better outcomes than their FFS Medicare counterparts, including lower rates of hospital readmission and higher rates of return to the community.”³
- According to another study co-authored by AHIP staff and published by the *American Journal of Managed Care*, readmission rates for MA enrollees were found to be about 13 percent to 20 percent lower than FFS.⁴
- Another study in *Health Affairs* found that MA plans had higher rates of annual preventive care visits (53 percent vs. 33 percent in FFS).⁵

To build upon this strong record of success, we support additional steps that would support MA plans as they develop the next generation of innovative programs and services to provide greater value to Medicare beneficiaries. Below we outline our recommendations for addressing this priority.

² CMS monthly enrollment files, May 2017. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/index.html?redirect=/mcradvpartdenroldata/>

³ Huckfeldt, Peter J., Escarce, Jose J., Rabideau, Brendan, Karaca-Mandic, Pinar, Sood, Neeraj. Less intense post-acute care, better outcomes for enrollees in Medicare Advantage than those in fee-for-service. *Health Affairs* 36(1): 91-100. January 2017.

⁴ Lemieux, Jeff, Sennett, Cary, Wang, Ray, Mulligan, Teresa, Bumbaugh, Jon. Hospital readmission rates in Medicare Advantage plans. *American Journal of Managed Care* 18(2): 96-104. February 2012.

⁵ Sukyung, Chung, Lesser, Lenard I., Lauderdale, Diane S. et al. Medicare annual preventive care visits: Use increased among fee-for-service patients, but many do not participate. *Health Affairs* 34(1): 11-20. January 2015.

Legislative Recommendations for Strengthening MA Program

Permanently Reauthorize Special Needs Plans

SNPs were established by Congress to provide new coverage options to beneficiaries with specific health care challenges. Medicare beneficiaries who enroll in these plans benefit from the coordinated care, disease management, and other initiatives our members have pioneered to ensure that they receive high quality health care across the entire continuum of services they need.

A *Health Affairs* study found that beneficiaries with diabetes in a Medicare Advantage SNP had “lower admission rates, shorter average lengths-of-stay in the hospital, lower readmission rates, slightly lower rates of hospital outpatient visits, and slightly higher rates of physician office visits than their fee-for-service counterparts.” Specifically, the study indicated that SNP enrollees had 9 percent lower hospital admission rates and 19 percent fewer hospital days, and 7 percent more office visits than beneficiaries in traditional Medicare.⁶

We encourage Congress to permanently reauthorize all SNPs including plans for beneficiaries who are dually eligible for both Medicare and Medicaid (D-SNPs), those for beneficiaries with specified chronic conditions (C-SNPs), and those for beneficiaries who require an institutional level of care (I-SNPs). Plans have made substantial investments to develop and operate these products, which are demonstrating success in improving beneficiary outcomes in comparison to the FFS program. Short-term reauthorizations create uncertainty and are inconsistent with the continued development of these innovative programs. Permanent reauthorization would alleviate this uncertainty and further our members’ commitment to creating programs tailored to enrollees with special needs.

Allow for Non-Uniform Benefits by Expanding Value-Based Insurance Design

Our members have pioneered innovative benefit designs that use research and clinical guidelines to promote better health, manage chronic conditions, and target populations with specific health needs. These types of value-based insurance design (VBID) features can improve quality of care

⁶ Cohen, Robb, Jeff Lemieux, Jeff Schoenborn, and Teresa Mulligan. Medicare Advantage Chronic Special Needs Plan Boosted Primary Care, Reduced Hospital Use among Diabetes Patients. *Health Affairs* Vol. 31, No. 1: 110-119. January 2012.

by encouraging individuals to access critically needed, high-value services and health improvement activities including preventive care. These strategies align with the national goals of providing patient-centered care, improving patients' overall health status, and changing financial incentives in a way that drives quality in health care delivery. We urge Congress to expand the use of VBID in the MA program nationally to permit more beneficiaries with chronic conditions to receive customized benefits through these models and to support participation by all MA organizations.

Allow MA Plans to be Considered Alternative Payment Models

The Medicare Access and CHIP Reauthorization Act (MACRA) defines an Alternative Payment Model (APM) as a CMS Innovation Center model, the Shared Savings Program, the Health Care Quality Demonstration, or a federally-required demonstration. MA plans have partnered with providers in developing APMs that contribute to the delivery of care that is of higher quality and lower cost than care delivered through FFS coverage.⁷ Accordingly, we believe that either legislative or regulatory action should be taken to allow MA plans to be defined as APMs. This step would level the playing field by providing risk arrangements in MA the same treatment as risk arrangements in traditional Medicare, resulting in more equitable opportunities for physicians. Numerous stakeholders, including physician groups, have addressed letters to the Administration, urging CMS to recognize MA alternative payment models.^{8,9}

Allow MA Plans to Include Telehealth Services in Basic Benefits Package

Health plans have embraced telehealth through the widespread use of nurse hotlines, remote monitoring services, electronic office visits, and other innovative ways of providing value to enrollees. These strategies have been found to increase access to a variety of health care services, including individuals without regular physicians and for Medicare beneficiaries. For example, one *Health Affairs* study found that access to telemedicine through a large public

⁷ Mandal, Alok K. et al. Value-based contracting innovated Medicare Advantage healthcare delivery and improved survival. *American Journal of Managed Care* 23(2): e41-e49. February 2017.

⁸ Letter to CMS Administrator Seema Verma, signed by Premier healthcare alliance, American College of Surgeons, American Medical Association, AMGA, American Osteopathic Association, America's Essential Hospitals, Healthcare Leadership Council, Healthcare Transformation Task Force, Medical Group Management Association, National Association of ACOs, May 31, 2017.

⁹ Letter to HHS Secretary Tom Price, signed by AHIP, CAPG, BCBSA, National Coalition on Health Care, Healthcare Leadership Council, Pacific Business Group on Health, Healthcare Transformation Task Force, National Committee for Quality Assurance, Alliance of Community Health Plans, Direct Primary Care Coalition, May 12, 2017

employer plan increased the amount of care delivered to patients who had no previous interaction with a provider¹⁰; another study found that off-hours physician services provided to nursing home residents via telemedicine reduced hospitalizations.¹¹

However, current law limits MA plans from incorporating telehealth benefits into their basic benefit package that go beyond the scope of services included in the FFS benefit. As a result, MA plans must use supplemental benefits funded by rebates or premiums to offer expanded coverage of remote access technologies, which has reduced flexibility in plan financing and limited the availability of other additional benefits or buy-downs of Medicare cost sharing. Permitting MA plans to broaden the use of telehealth in delivering basic benefits would be more consistent with modern medical practices and would enhance value and reduce premiums for enrollees.

Allow MA Plans to Offer Non-Medical Benefits as Supplemental Benefits

MA plans should be permitted to offer non-medical benefits as part of the supplemental benefits they provide to their enrollees. This includes housing and nutrition-related services as well as other social services that can help improve the overall well-being and health status of beneficiaries with chronic conditions. Allowing MA plans to offer non-medical benefits would be consistent with the goals of CMS' Accountable Health Communities Model, which is funding bridge organizations to screen Medicare beneficiaries for health-related social needs and refer them to, or provide them with, services that meet these needs.

Establish Unified Grievances and Appeals Process for Individuals Enrolled in D-SNPs

Currently, grievance and appeals procedures for beneficiaries in D-SNPs (i.e., plans for dual eligibles) are governed by separate state and federal requirements. These redundancies create confusion for beneficiaries and caregivers, and result in decreased efficiency and increased administrative burdens for plans. Enrollees in D-SNP plans would be better served by a unified grievance and appeals process.

¹⁰ Uscher-Pines, Lori, Mehrotra, Ateev. Analysis of Teladoc use seems to indicate expanded access to care for patients without prior connection to a provider. *Health Affairs* 33 (2):258-264. February 2014.

¹¹ Grabowski, David C., O'Malley, A. James. Use of telemedicine can reduce hospitalizations of nursing home residents and generate savings for Medicare. *Health Affairs* 33(2): 244-250. February 2014.

Eliminate the MA Benchmark Cap

To the extent that CMS is unable to identify statutory authority to do so, we urge Congress to repeal the benchmark cap that currently prohibits some MA plans from receiving the full bonus payments they have earned under the program's Star Ratings System. This existing policy continues to be problematic for beneficiaries enrolling in these plans, who are likely to experience additional costs or reduced supplemental benefits as a result, and is inconsistent with the broader health system goals of incentivizing high quality performance. Removing this cap is an important step toward preserving and rewarding the innovative programs and strategies through which MA plans are working to provide value to seniors and individuals with disabilities.

Thank you for considering our recommendations for expanding on the MA program's success in delivering coordinated care to Medicare beneficiaries. We look forward to working with the committee as you consider legislation addressing these important issues.



BETTER MEDICARE

ALLIANCE

STATEMENT FOR THE RECORD

**Submitted to the
House Ways and Means Committee
Subcommittee on Health**

Promoting Integrated and Coordinated Care for Medicare Beneficiaries

June 7, 2017

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Better Medicare Alliance (BMA) is a broad alliance of 85 organizations, including doctors and other professional health care providers, hospitals, health systems, aging service agencies, business groups,

retiree organizations, health plans as well as beneficiaries. Collectively, we support and advocate for Medicare Advantage and the innovative, quality care it delivers. BMA works to ensure the Medicare Advantage program is stable, accessible, high quality, cost effective, and financially viable through the ongoing support of policymakers. We achieve these goals through information, research, education, commentary on policy, and advocacy.

We appreciate the Committee's interest in Medicare Advantage. And we welcome the opportunity to comment on examining the ways Medicare Advantage serves high cost, high need Medicare beneficiaries and addressing the challenges in serving these populations. Policymakers, beneficiaries, the health care stakeholder community, and taxpayers together have a vested interest in ensuring that investments made in the Medicare Advantage program continue to yield integrated and coordinated care delivery, improved health outcomes, lower costs, and provider payment models that reward value over volume.

We further appreciate the Committee's support for Medicare Advantage, including the more than 300 Representatives and Senators from both sides of the aisle who signed letters earlier this year to the Centers for Medicare & Medicaid Services (CMS) in support of Medicare Advantage. Such a strong collection of lawmaker voices—from both Republicans and Democrats—is a testament to how Medicare Advantage is leading the way on coordinating care, reducing costs for those with chronic conditions, and empowering beneficiaries.

The Value of Medicare Advantage

Since 2010, enrollment in Medicare Advantage has grown by more than 60 percent, such that today more than 18.5 million Medicare beneficiaries—nearly one in three—choose Medicare Advantage plans to receive their Medicare benefits.¹ Moreover, beneficiaries are overwhelmingly satisfied with their Medicare Advantage plan's delivery of care and choice offerings, with 90 percent of beneficiaries saying they are satisfied with their plans, 91 percent saying they are satisfied with their preventive care coverage, and 90 percent saying they are satisfied with Medicare Advantage benefits and choice of providers.² It is easy to understand why the private health plan option within Medicare

¹ Centers for Medicare and Medicaid Services, Medicare Advantage Contract and Enrollment Monthly Summary Report, May, 2017.

² Morning Consult National Tracking Poll, March 11-16, 2016.

continues to grow in popularity. Medicare Advantage plans provide extra benefits and services that are not often included in the Traditional Fee-For-Service (FFS) Medicare program, such as:

- Case management
- Disease management
- Coordinated care
- Nurse help hotlines
- Wellness and prevention programs
- Enriched Part D benefits and prescription drug management tools
- Vision, hearing, and dental benefits coordinated with medical services

Many Medicare Advantage plans offer all these additional benefits with either zero or low premium, making the program even more attractive to potential enrollees. In fact, in 2016, 81 percent of Medicare Advantage beneficiaries nationwide had access to a zero premium plan.³

Medicare Advantage plans also offer beneficiaries an added layer of financial protection not available in FFS Medicare: annual dollar limits on out-of-pocket expenses, which is a yearly maximum on Medicare out-of-pocket expenses. FFS Medicare does not have an annual out-of-pocket maximum, meaning there is no limit to how much a beneficiary could spend on his or her health care in a given year.

Integrated and Coordinated Care

More and more Americans, particularly those over 65 years old who rely on Medicare, are living with serious chronic conditions and illnesses like diabetes, cardiac disease, hypertension, Chronic Obstructive Pulmonary Disease (COPD), dementia, and multiple other conditions. According to CMS, treatment of chronic illnesses now accounts for 93 percent of total Medicare spending. Some 68 percent of Medicare beneficiaries have at least two chronic conditions, and 14 percent have six or more. This cohort of Medicare beneficiaries with six or more chronic conditions account for almost half of total Medicare spending.⁴ They are high need, high risk individuals. BMA fervently believes that if we want to reduce Medicare spending, especially for these very complex patients, we need to be smarter about the way we finance and deliver care.

³ Avalere Health analysis using 2017 Medicare Advantage Landscape Files. [Web](#).

⁴ CMS, "Chronic Conditions Among Medicare Beneficiaries, Chartbook: 2012 Edition." [Web](#).

Medicare Advantage is at the forefront of delivering early intervention, care management, and patient engagement that improves outcomes for individuals living with chronic conditions. While much is already being done to improve care for these patients, we know we can do more to encourage innovative care delivery that addresses the social determinants of health and connects beneficiaries to the care they need. This includes greater flexibility in Medicare Advantage benefit design to offer more tailored benefits in Medicare Advantage plans such as community based care, home care, telemedicine, and care that addresses social determinants of health (e.g., transportation and meals). These advances would improve the ability of Medicare Advantage plans and providers to offer more targeted care and achieve better outcomes for patients with chronic conditions.

Special Needs Plans (SNPs)

Established in 2003, SNPs are a type of Medicare Advantage plan that have the authority to provide specialized care to serve beneficiaries who are dually-eligible for Medicare and Medicaid (D-SNPs), have certain chronic conditions (C-SNPs), or receive long-term care in an institutional setting such as a Skilled Nursing Facility (I-SNPs). In addition to providing all Medicare Part A and Part B benefits, SNPs must also exceed these core benefits by providing individualized care plans, tailored benefits, and care coordination.

More than 2.3 million beneficiaries are enrolled in nearly 600 SNPs nationwide.⁵ SNP beneficiaries often have lower incomes, less support, and more complex medical conditions than other Medicare beneficiaries. This is why SNPs are so critical to our high need populations: they provide care tailored to complex beneficiaries through care management tools, such as care managers, interdisciplinary teams, specialized provider networks, enhanced home and community-based services.

SNPs have proven their value to beneficiaries and our health care delivery system by lowering rates of hospitalizations and readmissions. A 2012 study found that people with diabetes in C-SNPs—particularly nonwhite beneficiaries—had lower rates of hospitalization and readmission than their peers in FFS Medicare.⁶

⁵ CMS enrollment data, May, 2017.

⁶ Robb Cohen, Jeff Lemieux, Jeff Schoenborn, Teresa Mulligan, "Medicare Advantage Chronic Special Needs Plan Boosted Primary Care, Reduced Hospital Use Among Diabetes Patients," *Health Affairs*, January 2012 vol. 31 no. 1 110-119.

Without Congressional action, SNP authority will expire at the end of 2018. Congress has continued to reauthorize the program since 2003 because SNPs have been recognized as a valuable care delivery model for high cost, high need individuals. Enrollment in SNPs has grown by 65 percent over the last five years.⁷ Additionally, the Medicare Payment Advisory Committee (MedPAC) has recommended permanent reauthorization of the program.⁸ SNPs should be permanently authorized to ensure beneficiaries have access to the quality, coordinated, and high value care offered by SNPs.

Successful Care Management Models in Medicare Advantage

BMA commends the Committee's attention to a recently commissioned report from the Robert Graham Center, entitled, "[Bright Spots in Care Management in Medicare Advantage](#)." The report examines care management under Medicare Advantage, with the premise that the financial framework of risk-based, capitated payments under Medicare Advantage offers the opportunity to improve service delivery through care management to better meet patient needs and improve outcomes. The authors begin by highlighting the current systemic care fragmentation which exists in our health care delivery system, and identifying preventable wasted resources and inefficiencies.

On average, Medicare patients see seven physicians at four practices.⁹ The negative impact of poor coordination can be seen in the prevalence of repeated tests and conflicting information between clinicians.^{10, 11} Nearly 20 percent of FFS Medicare beneficiaries are re-hospitalized within 30 days of discharge, and half of those patients failed to see their primary care provider in the interim.¹²

⁷ Centers for Medicare & Medicaid Services. Enrollment in Special Needs Plans, 2012 to 2017. [Web](#).

⁸ MedPAC. "Medicare Advantage." MedPAC. N.p., June 2016. [Web](#).

⁹ Pham, H.H., Schrag, D., O'Malley, A.S., Wu, B., & Bach, P.B. (2007). Care patterns in Medicare and their implications for pay for performance. *New England Journal of Medicine*, 356(11), 1130–1139.

¹⁰ Stremikis, K., Schoen, C., & Fryer, A-K. (2011). *A call for change: The 2011 Commonwealth Fund Survey of Public Views of the US Health System*. New York: The Commonwealth Fund. Accessed January 27, 2017, from https://www.researchgate.net/profile/Cathy_Schoen/publication/51035452_A_call_for_change_the_2011_Commonwealth_Fund_Survey_of_Public_VIEWS_of_the_U.S._Health_System/links/5479caef0cf205d1687fa93a.pdf

¹¹ Osborn, R., Moulds, D., Squires, D., Doty, M.M., & Anderson, C. (2014). International Survey Of Older Adults finds shortcomings in access, coordination, and patient-centered care. *Health Affairs*, 33(12), 2247–2255. doi:10.1377/hlthaff.2014.0947

¹² Jencks, S.F., Williams, M.V., & Coleman, E.A. (2009). Rehospitalizations among patients in the Medicare fee-for-service program. *New England Journal of Medicine*, 360(14), 1418–1428.

A 2012 National Academy of Medicine (NAM) report concluded that care delivery fragmentation leads to coordination and communication challenges for patients and clinicians and estimated that \$765 billion of health care spending is wasted, or leads to little improvement in health or in quality. The authors estimated that \$130 billion of waste is attributable to inefficiently delivered services.¹³

The authors of the “[Bright Spots in Care Management in Medicare Advantage](#)” report maintain that it is important to identify and better define the essential elements prevalent in successful models of care management so they can be replicated by plans and providers and incentivized by policymakers. The report concludes with the identification of five essential elements of effective care management in the form of a blueprint and recommendations to policymakers.



¹³ Institute of Medicine. (2013). Best care at lower cost: The path to continuously learning health care in America. Washington, D.C: National Academies Press. doi: <https://doi.org/10.17226/13444>

These recommendations to policymakers include:

- Further evaluation and testing of models based on the blueprint presented in this report.
- Evaluation of differences in outcomes and cost between plans and provider organizations that use care management.
- Expansion of provider contracts in value based, risk assumption models that include care management.
- Incentives for the use of risk stratification to identify high need, high risk patients.
- Incentives for the use of care management teams that include appropriate personnel, including a Registered nurse, social worker and/ or a community health worker working closely with clinical staff.
- Align different payment systems and benefits for dually eligible individuals and patients with multiple chronic conditions through the use of value based capitated payment.
- Provide flexibility in payment and coverage to enable providers to treat patients at the most appropriate site of care and to offer additional benefits as needed to meet care goals.

Even though Medicare Advantage has had many successes to date and beneficiaries are increasingly choosing this valued option, there are some specific policy areas where Congress can take action to further bolster Medicare Advantage's initiatives in providing care coordination, offering greater flexibility in services covered as supplemental benefits, expanding the use of effective chronic disease management, and pioneering value-based models.

Legislative Recommendations for Better Enabling Medicare Advantage to Manage Health Needs of High Cost Medicare Beneficiaries:

Specifically, the following Congressional actions would enhance the innovative programs and transformative improvements in care for high need, high cost beneficiaries available in Medicare Advantage:

- **Expand the Center for Medicare & Medicaid Innovation (CMMI) Medicare Advantage Value-Based Insurance Design (VBID) Model to all states:** The VBID model allows Medicare Advantage plans to offer supplemental benefits or reduced cost sharing to enrollees with specified chronic conditions, focused on the services that are of highest clinical value to them. The model tests whether this can improve health outcomes and lower expenditures for Medicare Advantage enrollees.
- **Permanently Extend Medicare Advantage Special Needs Plans (SNPs):** SNPs enable improved team-based care by coordinating benefits for dual-eligible, chronically ill, and institutionalized beneficiaries. Current SNP authorization expires December 31, 2018. Permanently authorizing the SNP program will furnish health plans and providers a stable environment to allow for greater planning of and investment in the successful care models that SNPs provide to high-need beneficiaries.
- **Expand Supplemental Benefits in Medicare Advantage:** BMA urges Congress to enact into law provisions which would give Medicare Advantage plans greater flexibility to offer a wider array of supplemental benefits (using rebate dollars) to address chronic conditions. Currently, Medicare Advantage plans may offer supplemental benefits that are defined as “primarily health related.” The current definition should be modified to include other services necessary to enable patients with chronic conditions to follow clinical recommendations and improve their health. Such services could include: healthy meals, care in the home, and transportation to medical appointments.
- **Increase Telemedicine Benefits in Medicare Advantage:** Another advancement to help better manage care for high-need, high-cost Medicare beneficiaries would allow a Medicare Advantage plan to offer additional, clinically appropriate telemedicine benefits in the annual bid, above and beyond the services currently reimbursed under Medicare Part B. Currently, Medicare Advantage is constrained to the limited amount of telemedicine services included in FFS Medicare, and is not able to include other innovative telemedicine services in bids. Medicare Advantage plans can choose to provide additional telemedicine benefits via

supplemental benefits (using rebate dollars) with CMS approval.

Medicare Advantage offers an option that meets the goals of more integrated care, greater patient engagement, and improved health outcomes for Medicare beneficiaries. BMA believes that these legislative recommendations will advance the goals of facilitating the delivery of high quality care, increase Medicare program efficiency, smooth care transitions, improve patient outcomes, and contain costs in Medicare spending.

BMA thanks the Committee for considering our recommendations for strengthening the Medicare Advantage program. We further appreciate the convening of this very important Hearing, and the ensuing discussion about initiatives to better enable Medicare Advantage to deliver high value, quality, cost-effective health care to beneficiaries with multiple chronic illnesses.

We look forward to working with the Committee and serving as a resource as you consider legislation addressing these important issues.





June 21, 2017

The Honorable Pat Tiberi
US House of Representatives
Ways and Means Committee
Chairman, Subcommittee on Health
1100 Longworth House Office Building
Washington, DC 20515

The Honorable Sander Levin
US House of Representatives
Ways and Means Committee
Ranking Member, Subcommittee on Health
1100 Longworth House Office Building
Washington, DC 20515

Re: June 7, 2017 Hearing entitled "Medicare Advantage, Promoting Integrated and Coordinated Care for Medicare Beneficiaries"

Dear Chairman Tiberi and Ranking Member Levin:

As an organization that has pioneered an array of care delivery innovations that improve the lives and independence of those who are frail, sick, and disabled, we appreciate the opportunity to submit comments to the recent hearing you held. We offer our thoughts as you contemplate policy changes that affect the dual-eligible populations and the Special Needs Plans program.

Who We Are

Based in Massachusetts, CCA is a not-for-profit, community-based healthcare organization dedicated to improving the care and well-being of underserved individuals with complex health needs. Relying on risk adjusted capitated premiums from the state and federal governments, we serve the frail, elderly and those with disabilities, multiple chronic conditions, behavioral health and social needs who are dually eligible for Medicaid and Medicare. CCA's nationally recognized model for delivering care has been shown to improve quality and health outcomes while reducing the overall cost of care.

Our mission is to provide the best possible care individually tailored to the members and patients we serve. CCA delivers an array of services including enhanced primary care, behavioral health, geriatric and long-term services and supports, utilization management, assessment and care coordination functions. Today, CCA serves close to 22,000 total members between its two health plans: Senior Care Options, or SCO (a HMO- Special Needs Plan), and One Care (Massachusetts's demonstration Medicare-Medicaid plan). CCA's One Care program is the top-rated Medicare-Medicaid Plan in the country (based on the 2016 CAHPS survey) and, with 83 percent of market share, it is the largest plan of its kind in the Commonwealth. CCA's SCO program, meanwhile, is nationally recognized for excellence, earning a 4.5-Star Rating from CMS.

30 Winter Street, Boston, MA 021081 Tel: (617) 426-0600 | Fax: (617) 426-3097

CCA strives to help members maintain an independent lifestyle despite significant clinical and social barriers. Although 75 percent of CCA SCO members are nursing home eligible, over 95 percent of them live independently in their community. For 2/3 of CCA's SCO members, English is not the primary language, while 70 percent of them have four or more chronic conditions thus requiring assistance with activities of daily living. Among our One Care members, 75 percent have been diagnosed with behavioral health issues, 45 percent have clinically diagnosed depression, and 7 percent are homeless.

Our Services

In both of its SCO and One Care programs, CCA provides all the Medicaid and Medicare benefits for which members are eligible, oftentimes offering additional benefits, while coordinating these benefits through individualized care plans. Through the SCO program, members have access to broad coverage including dental services, prescription drugs, eyeglasses, hearing aids, and in-home care and long-term care support. Additionally, members have around-the-clock access to nurses and medical staff. This coordinated effort, led by a primary care provider, allows beneficiaries to receive personalized, in-home assistance from trusted partners in the community.

Members enrolled in CCA's Senior Care Options and One Care plans receive dental and vision coverage, behavioral health services, transportation, access to most major hospital systems and primary care practices, personal care attendant services as needed, and assistive technologies. Most notably, One Care members receive this comprehensive suite of services while incurring zero out-of-pocket costs.

One particular focus for CCA is addressing the behavioral health issues of its members. Coordinated care for members with behavioral health issues is critical for enhancing quality of life and ensuring that they receive the right kind of care. CCA has found that members with serious, persistent mental health issues have drastically reduced lifespans. This lifespan disparity is not attributed to suicide, but rather other factors such as insufficient preventive health maintenance, which can lead to complications like cardiovascular disease. Evidence suggests a compelling need for a primary care presence to be actively engaged with individuals with mental illness. For behaviorally complex members, CCA uses a model where social workers and psychologists conduct behavioral health assessments and provide consultation, education, and support to primary care teams regarding behavioral health treatment. This team approach results in improved, individualized care plans for members. In addition, CCA arranges to have care coordinators partner with hospitals to help oversee care for members who have been admitted for mental health or substance abuse treatment.

Our Outcomes

Due to the flexibility provided by the federal and state government, CCA delivers exceptional care to its members, providing improved outcomes and ensuring consistent member satisfaction scores year-over-year. CCA has consistently maintained a 4-star rating or higher from the Centers for Medicare and Medicaid Services' Medicare Advantage Star Ratings System. Most recently, CCA earned a 4.5-star rating and continues to strive for improvement. Demonstrating its high level of membership satisfaction, CCA's One Care program was the top-rated Medicare-Medicaid Plan in the country according to the 2016 MA- Prescription Drug Consumer Assessment of Healthcare Providers and Systems survey.

CCA's unique approach to care has led to a significantly reduced hospitalization rate in its senior population while also delivering high quality of care. CCA's approach to integrated, quality care has led to direct cost savings, and earned the health system top marks in both quality and member satisfaction.

Policy Recommendations

As Congress considers reauthorizing the Medicare Advantage Special Needs Plans (SNP) program, we offer the following recommendations:

Permanent Re-Authorization

CCA strongly supports permanent reauthorization of the Dual-Eligible SNP program (D-SNP). While we appreciate the short-term reauthorizations that Congress has passed to date, permanent authorization to the D-SNP would provide much needed stability for plans around the country that assume clinical and financial responsibility for Medicare and Medicaid benefits.

MedPAC Recommendations

We urge Congress to consider the Medicare Payment Advisory Commission's (MedPAC) 2013 recommendations for D-SNPs. MedPAC recommended Congress should:

- Grant the Secretary of Health and Human Services (HHS) authority to align the Medicare and Medicaid appeals and grievances process;
- Direct the Secretary of HHS to allow SNPs to market the Medicare and Medicaid benefits they cover as a combined benefit package; and
- Direct the HHS Secretary to allow SNPs to use a single enrollment card that covers beneficiaries' Medicare and Medicaid benefits.

As a practical matter, CCA can attest to the benefits of implementing these MedPAC 2013 recommendations. In Massachusetts, for example, pursuant to CCA's SCO contract and under the One Care Demonstration, CCA is required to provide its members with a single enrollment card which has streamlined the transactional component of providing D-SNP participants with health care services. Furthermore, dispensing a single enrollment card correlates with consolidating member benefits into one package and is a symbolic gesture designed to simplify the experience of beneficiaries who often find difficulty managing the complexity of health insurance, which is complicated by the need for multiple insurance cards.

Passive Enrollment

CCA strongly supports expanding passive enrollment for individuals dually eligible for Medicare and Medicaid services. Passive enrollment effectively moves beneficiaries into a managed care environment in which services can be individually tailored while patient needs can be more holistically addressed. Not only does passive enrollment increase SNP participation, but by simply distributing a passive enrollment notice letter we can raise consumer awareness, often resulting in voluntary enrollment in SNPs. Enhancing flexibility for passive enrollment remains a priority for CCA, as voluntary enrollment fails to maximize participation by eligible beneficiaries in SNPs. This results in individuals seeking costlier, less effective health care services. Expanding passive enrollment will increase access to managed care programs designed to reduce costs.

Star Ratings System

We support Congress directing the Department of Health and Human Services to develop a long-term solution to Medicare Advantage Star Ratings program so that the Star Ratings more accurately measure quality for beneficiaries in D-SNPs. As the Subcommittee is aware, the preliminary report by the Office of the Assistant Secretary for Planning and Evaluation (ASPE) indicated that "dual status" results in lower scores on quality measures due to socioeconomic status. We support requiring CMS to adjust the Star Ratings for social risk and quality measures relevant to the populations served by SNPs. Such adjustments would facilitate a more accurate picture of plan quality and better enable beneficiaries to make an apples to apples comparisons by plan type when considering enrollment.

Medicare-Medicaid Coordination Office

We recommend that Congress designate the CMS Medicare-Medicaid Coordination Office (MMCO) as the point of contact for D-SNPs. As one of the MMP participants, we have found the collaboration with MMCO to be invaluable as we develop needed models of care. If MMCO is given more authority to develop alignments between Medicare and Medicaid, the needs of these complex populations would be greatly improved.

Conclusion

The Medicare Advantage D-SNP program is a lifeline for many of the most vulnerable citizens in this country. CCA has demonstrated how successful these programs can be when implemented with thoughtfulness and careful execution. CCA stands ready to assist Congress with the continuation and development of coordinated care services and will continue to serve as a resource as needed. For further information, please contact Josh Krintzman at jkrantzman@commonwealthcare.org.

Sincerely,



Christopher D. Palmieri
President & Chief Executive Officer



Deliver Results, Innovation and Value for *Everyone*

STATEMENT FOR THE RECORD

SUBMITTED TO THE

House Ways & Means Health Subcommittee

Medicare Advantage Hearing on Promoting Integrated and Coordinated Care for Medicare Beneficiaries

June 7, 2017

Submitted by the DRIVE Health Initiative
<https://drivehealth.org/>

In recent years, many large employers have worked to implement value-driven plan designs, develop value-based payment models for providers, and incentivize employees to seek the highest quality and most efficient care. In order to have the maximum impact on the quality and affordability of care throughout the health care system, however, it is essential for the Federal government to align its programs with private-sector purchasing strategies. This alignment will produce the kind of clear and consistent market signal needed to fully transform the delivery system into one focused on value.

We need policymakers to recognize the Federal government's role in moving the U.S. toward a value-based health care system, grounded in market-based strategies and buttressed by healthy competition, transparency, and consumer engagement. Private-sector innovations can inform Medicare policy, which – if adopted – can drive change throughout the health care system, benefitting Medicare enrollees and taxpayers.

The DRIVE Health Initiative – a partnership between The ERISA Industry Committee (ERIC) and the Pacific Business Group on Health (PBGH) – was developed and launched to promote the use of value-based purchasing strategies. Our goals are to share information with policymakers on the value-based care strategies that private-sector employers are already adopting, and to encourage Congress and the Administration to consider changes in the law and regulations that will reduce health care costs and improve quality.

Value-Based Insurance Designs Offered by Private-Sector Employers

For decades, private-sector employers have sought to offer to their employees high-quality health care coverage at an affordable price. However, the ever-increasing cost of medical services has made it difficult for employers to offer affordable benefits, while also remaining competitive in a growing, global marketplace. In response to these challenges, employers have adopted innovative strategies to manage their health care spending, while also enabling them to improve health outcomes for their employees and families. One strategy that has proven effective in improving health outcomes and lowering costs is value-based insurance design.

In short, a value-based insurance design allows an employer to reduce or waive cost-sharing requirements if an employee is accessing high-value services. This approach is intended to encourage employees to obtain necessary medical care, while discouraging utilization of unnecessary medical services – this is especially important in cases of chronically ill patients. Employers have utilized value-based insurance designs to encourage the following:

- Use of specialty medications to manage chronic conditions;
- Use of high-performing medical providers that meet high standards of quality, patient experience, and total cost of care (e.g., “centers of excellence”); and
- Participation in worksite wellness programs.

Use of specialty medications to manage chronic conditions

Several private-sector employers have put into place a value-based insurance design that lowers cost-sharing for certain specialty medications. This type of plan design ensures that certain high-risk employees who need the specialty drugs to manage their chronic illnesses can access these medications. Under the traditional tiered drug formulary, high-risk employees are often discouraged from accessing specialty drugs because of increased cost-sharing for these much-needed medications. This often results in neglect and mismanagement of their chronic illness, ultimately resulting in higher health care spending and worsening health. By using a value-based plan design which lowers the cost-sharing for necessary medical care – for example, lowering the cost-sharing for specialty drugs so high-risk employees can better manage a chronic condition – private-sector employers have reduced their health benefits spending while also improving outcomes for the patient.

Here's how these employers did it: Employers partnered with their providers to identify particular specialty medications that consistently deliver outstanding value for specific medical conditions such as rheumatoid arthritis, HIV, multiple sclerosis, and cancer. In response, these employers lowered the cost-sharing for those specialty medications that were found to be effective in managing these conditions. While specialty medicines used to manage chronic conditions may come at a cost, those costs pale in comparison to the catastrophic costs associated with failure to manage a chronic condition – usually culminating in extremely expensive hospital stays, surgical procedures, recoveries and the therapies – in addition to the serious tolls taken on patients, as well as the missed work and reduced productivity that results. Making it easier and more affordable for these patients to access their specialty medications not only benefited the employer in the form of lower health care spending and increased productivity, but high-risk employees are living better lives because of their participation in an appropriate chronic care management regime.

Use of high-performing medical providers that meet high standards of quality, patient experience, and total cost of care

Another way employers are using value-based plan designs is by reducing the cost-sharing for medical services obtained through “centers of excellence.” These providers are typically health systems that have met the highest standards of achievement for treating a specific disease (e.g., cancer or heart disease) or providing medical services for a particular episode (e.g., hip and knee replacements or spine care). The idea is to encourage employees to select medical providers with high quality ratings and experience for a given procedure or medical condition, by providing a financial incentive to employees who choose to receive care from those providers.

A good example of the use of value-based insurance design is the Employers Centers of Excellence Network (ECEN), which is managed by the Pacific Business Group on Health on behalf of large employers. If an employee or family member chooses to receive care at one of the designated centers of excellence, the deductible and coinsurance are waived. As a result, program participation has been very high, and it has achieved outstanding results:

- Patients have achieved better outcomes with lower rates of preventable complications;
- Patients who chose another hospital instead of one of the centers of excellence were nine times more likely to be readmitted to the hospital;
- Patients have better quality of life, less pain, and better function;
- Employers and their employees have saved millions of dollars by avoiding unnecessary services; and
- 100% of participating patients would recommend the ECEN joint replacement program.

Participation in various worksite wellness programs

There is yet another way employers are deploying value-based insurance designs: An employer may create a program to encourage employees to quit smoking, or participate in health risk assessments and biometric screenings, or enroll in a disease management program. By providing incentives to obtain preventive care and adhere to wellness visits and treatments such as medications to control blood pressure or diabetes at low to no cost, private-sector employers save money by reducing future expensive medical procedures. And, employees are living happier and healthier lifestyles.

Value-Based Insurance Design in Medicare Advantage Plans

The DRIVE Health Initiative believes Congress has the opportunity to allow Medicare Advantage plans to mirror what private-sector employers are already doing. More specifically, we believe Congress can learn from private-sector employers and allow Medicare Advantage plans to offer the same type of value-based plan design programs:

- To encourage the use of specialty medications to better manage chronic conditions;
- To promote access to high-value, high-quality medical providers; and
- To encourage healthy behaviors through wellness/preventive services.

As of January 1, 2017, Medicare Advantage plans are already on their way to adopting value-based insurance design models through the Medicare Advantage Value-Based Insurance Design Model (the “MA VBID Model”). The DRIVE Health Initiative believes that the MA VBID Model will show policymakers in Congress and in the Department of Health and Human Services (HHS) that offering value-based insurance designs that reduce cost-sharing (1) for accessing high-value services, (2) for accessing high-value providers, and (3) for enrollees participating in preventive/disease management programs, can improve health outcomes and lower health care costs not only for the Federal government, but also for Medicare Advantage enrollees.

The DRIVE Health Initiative urges Congress to expand the MA VBID Model to all 50 States. The DRIVE Health Initiative also urges Congress to continue funding – and supporting – the Centers for Medicare and Medicaid Innovations (CMMI), to ensure that the MA VBID Model (and other related value-based care and shared-risk models) continue to be piloted, and ultimately implemented nationwide.

The DRIVE Health Initiative intends to serve as a constructive resource for Congress and CMMI in the areas of value-based insurance designs, alternative provider payment models, and better performance measures. We will share data and evidence on innovations launched by private-sector employers, and we will provide guidance on how these innovations can be incorporated into our nation's public and private health programs so we can continue to move to a value-based health care system.





STATEMENT FOR THE RECORD

Submitted to the House Ways and Means Committee Subcommittee on Health

*Medicare Advantage:
Promoting Integrated and Coordinated Care for Medicare Beneficiaries*

June 7, 2017

Chairman Tiberi, Ranking Member Levin, and members of the House Ways and Means Committee Subcommittee on Health, we appreciate the opportunity to submit this statement for the record for the hearing entitled “Promoting Integrated and Coordinated Care for Beneficiaries” held on June 7, 2017. EmblemHealth is the largest community-based nonprofit health plan in the country, and with our partner ConnectiCare, serves 160,000 Medicare Advantage enrollees in New York and Connecticut who have come to rely on our innovative approach to providing high quality health care services.

We are proud to be part of the Medicare Advantage program and to have contributed to its accomplishments. Research demonstrates Medicare Advantage enrollees are more likely than beneficiaries in the Medicare fee-for-service (FFS) program to receive primary and preventive care and spend less time in the hospital for conditions that are better treated through disease and care management. The success of Medicare Advantage plan initiatives is the model for value-based care programs now being implemented throughout the Medicare program.

EmblemHealth and ConnectiCare are committed to continuing the Medicare Advantage program’s tradition of innovation. In New York, we are partnering with a physician group AdvantageCare Physicians to bring the health plan model to more beneficiaries, including those living in low-income neighborhoods. In Connecticut, we are working with another physician group, CliniSanitas that primarily serves the Hispanic community to provide culturally appropriate, clinically effective care.

However, as well as Medicare Advantage is working today, there are changes that would make it an even stronger program. Below we outline five recommendations:

- Permanently Reauthorize Special Needs Plans
- Include Medicare Advantage Plans in the Definition of Alternative Payment Models (APMs)
- Provide Plans Greater Flexibility to Offer Tailored Benefit Designs
- Reverse Funding Cuts to Medicare Advantage Employer Group Waiver Plans
- Remove Barriers to Plan Innovation

Permanently Reauthorize Special Needs Plans

The Medicare Modernization Act of 2003 established Medicare Advantage Special Needs Plans (SNPs), which are permitted to limit enrollment to individuals who are Medicare-Medicaid dual eligibles, have chronic conditions, or require an institutional level of care. In establishing SNPs, Congress recognized that not all Medicare beneficiaries are the same, and permitting health plans to develop targeted programs and expertise is the best way to meet individuals’ unique needs. The Centers for Medicare & Medicaid Services (CMS) has developed rules to make sure these unique needs are being met. For example, Dual Eligible SNPs (D-SNPs) must establish an approved Model of Care that includes additional requirements specific to this population. D-SNPs must also have contracts in place with state Medicaid programs to coordinate requirements and benefits with these Medicare Advantage plans.

However, despite SNPs' successes, enrollees still must face the uncertainty of periodic Congressional reauthorizations that do not guarantee these plans will be able to operate in the longer term. We strongly believe it is time to permanently reauthorize SNPs without further conditions. SNPs demonstrate the importance of tailoring plans and oversight requirements to the specific needs of unique populations and the value of allowing organizations to focus efforts to serving them. Subjecting the millions of beneficiaries enrolled in SNPs to the uncertainty of Congressional reauthorization risks jeopardizing the success of these programs.

Include Medicare Advantage Plans in the Definition of Alternative Payment Models

The Medicare and CHIP Reauthorization Act of 2015 (MACRA) makes significant changes to improve health care delivery in the Medicare program. MACRA creates new Advanced Alternative Payment Models (APMs) to provide incentives for physicians to engage in value-based purchasing arrangements. Yet the law prohibits Medicare Advantage plans from being designated as APMs and denies access to related bonuses to physicians working exclusively with our plans by requiring them to retain at least 25 percent of their Medicare participation¹ in the outdated FFS program.

Congress's attention to promoting more value-based, risk-bearing arrangements in Original Medicare is understandable. Existing FFS payment structures generally provide incentives for physicians to provide more services, not better care. However, MACRA's focus on the Original Medicare program establishes an unlevel playing field that is likely to influence a provider's decisions to participate in Medicare Advantage plan networks.

The implications of excluding Medicare Advantage plans and their providers from participation in Advanced APMs are extremely problematic. By limiting government payment bonuses to physicians who work primarily with Medicare Advantage plans, the law may drive providers and beneficiaries into FFS-based APMs that do not have the proven track record of Medicare Advantage plans. Doing so could undermine further development of Medicare Advantage programs that have served as the driving force for innovations throughout the program. Also, Medicare Advantage plans are subject to a rigorous regulatory environment that is unmatched in the FFS program in which APMs will continue to operate.

We urge Congress to amend MACRA to designate Medicare Advantage plans that have value-based arrangements with physicians as APMs and permit providers who work predominately in plan networks to receive APM bonuses. These changes are consistent with MACRA's goals to disseminate health plan innovations that are moving Medicare and the health care system away from volume and towards the delivery of higher quality, more cost-effective care.

Reverse Funding Cuts to Medicare Advantage Employer Group Waiver Plans

Approximately 250,000 beneficiaries in New York State and 3 million individuals nationwide receive Medicare coverage through Medicare Advantage Employer Group Waiver Plans

¹ Based on total Medicare payments or 20 percent of Medicare beneficiaries served by the provider.

(EGWPs)². However, in 2016 CMS announced funding cuts that have increased costs and reduced benefits to retirees enrolled in these plans.

Federal policy should not increase costs for employers that are doing the right thing and contributing to their retirees' health care coverage. CMS should reverse these funding reductions and support employer-Medicare Advantage plan collaborations that are improving care and reducing costs for beneficiaries.

Provide Plans Greater Flexibility to Offer Benefits Tailored to the Needs of Their Enrollees.

CMS now permits Medicare Advantage plans in seven states to implement value-based insurance designs (VBID) to address the specific needs of enrollees with chronic conditions. We support expanding access to this demonstration project nationwide. Doing so would permit Medicare Advantage plans to tailor benefit designs to individuals with chronic conditions. For example, CMS regulations now limit Medicare Advantage organizations from offering enrollees with diabetes lower cost-sharing for insulin or other appropriate drugs than is available to other beneficiaries in the same plan. VBID would permit plans to do so to improve compliance with effective treatments. Expanding VBID across the country will ensure these commonsense tools can be available to beneficiaries in every state.

Remove Barriers to Plan Innovation

Private sector plans participating in the Medicare Advantage and Part D programs have been at the forefront of delivery system reforms that are improving the Medicare program. Medicare Advantage plans' emphasis on prevention is now a key component of the program, and our value-based payment arrangements with physicians and other providers have served as the model for ongoing reforms. However, plan innovation has often been limited by CMS rules. Below we provide several recommendations to better support plan innovations that improve care and reduce costs for beneficiaries and taxpayers.

1. **Allow plans greater flexibility to use prescription drug management techniques.** The 2016 Medicare Trustees Report projected Part D expenditures will increase at a faster rate during the next ten years than the Medicare program as a whole.³ Medicare Advantage plans have developed proven strategies to promote use of the most clinically appropriate, cost-effective medications. CMS should reduce barriers to using these tools. For example:
 - a. **Eliminate the "two drugs per class" requirement.** Part D plans must provide coverage for at least two drugs in each category and class, which limits plans' ability

² Based on an analysis of CMS data for January 2017 found at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAAdvPartDEnrolData/Monthly-Enrollment-by-Contract-Plan-State-County-Items/Monthly-Enrollment-by-CPSC-2017-01.html?DLPage=1&DLEntries=10&DLSort=1&DLSortDir=descending>.

³ 2016 Medicare Trustees Report, page 201.

to encourage beneficiaries to use more clinically appropriate drugs and leverage to negotiate deep discounts and rebates that reduce beneficiary and taxpayer costs. We believe CMS has the authority to eliminate this requirement while maintaining beneficiary access to needed prescription drugs through the existing exceptions process.

- b. **Provide plans with greater flexibility to make mid-year formulary changes.** CMS permits Part D plans to add drugs to formularies during the plan year but permits “negative formulary changes” only after a lengthy review process. We understand the concerns that motivated this policy, but in practice limiting mid-year changes that promote utilization of clinically superior drugs when they are introduced puts greater burdens on providers at the beginning of the next plan year when such changes can be made. CMS should permit Part D plans greater flexibility to make midyear changes based on recommendations by plan Pharmacy & Therapeutics Committees.
 - c. **Establish conflict of interest and transparency standards for compendia making coverage decisions.** Part D plans must provide coverage for all indications recommended by specified compendia even though these organizations (with the exception of compendia evaluating cancer drugs) are not required to have conflict of interest and transparency policies in place. These compendia may require coverage of medications for indications that the plan’s Pharmacy & Therapeutics Committee does not find to be appropriate, which further limits plan tools to ensure beneficiaries receive the most clinically appropriate cost effective medications. CMS should use its leverage to strongly encourage new standards for national compendia determining Part D coverage policy.
2. **Stabilize the management process.** CMS issues hundreds of memos each year that require action by Medicare Advantage and Part D plans. This is inconsistent with how health plans work with other business partners. We urge CMS to issue memos directing action no more frequently than on a monthly basis and provide plans with sufficient lead time to implement required activities.
 3. **Better target audit activities.** EmblemHealth understands that program audits are a fundamental component to ensuring organizations are in compliance with program rules and providing good care to beneficiaries. However, despite concerns raised by plans for many years, audits continue often to be duplicative and not risk-based, causing plans to use resources better spent on improving beneficiary care on achieving good audit results. We urge CMS to reconsider its existing strategies to ensure the agency’s auditing practices are consistent with program goals.
 4. **Provide plans with greater flexibility to tailor the content and method of distribution of member materials.** CMS has developed numerous model materials that are often too complicated for even the most sophisticated beneficiary. There are several actions the agency could take that would improve the usability of the information plans provide to beneficiaries.

- a. **Improve model materials.** CMS's models are often not useful, and plans creating their own materials are subject to a lengthy and overly complicated review process. The agency should convene plans, beneficiaries, and other stakeholders to improve model materials and provide plans with greater flexibility to make changes that improve the usability for beneficiaries.
- b. **Permit plans to send shorter versions of lengthy documents.** Medicare Advantage and Part D plans are required to send Annual Notices of Change to enrollees by October 1st of each year. These documents provide important information on key changes to the beneficiary's plan to help him/her make an informed choice during the annual election period. However, the CMS model is too lengthy, increasing complexity for beneficiaries and costs for plans. The agency should permit plans to send more useful summaries of changes in place of the full Annual Notice of Change that include phone numbers or websites to request information currently provided in the longer document. CMS should also consider other materials (e.g., the Evidence of Coverage) where providing more flexibility to change models without going through the review process would improve the beneficiary experience.
- c. **Allow plans to provide materials electronically unless the beneficiary opts out.** CMS requires plans to mail member materials unless beneficiaries opt in to electronic transmission. Permitting plans that have beneficiary email addresses to transmit materials electronically or request consent to do so via email would make the information more accessible to beneficiaries and reduce unnecessary costs.

We greatly appreciate the opportunity to submit this statement and thank the Subcommittee for its continuing leadership and interest in the Medicare Advantage program.



**Statement of
Genesis Healthcare Inc.
Submitted to the
Subcommittee on Health, House Ways and Means Committee
Hearing on Promoting Integrated and Coordinated Care for Medicare Beneficiaries
June 7, 2017**

Chairman Tiberi and Members of the Subcommittee on Health:

On behalf of Genesis Healthcare, the nation's largest skilled nursing and rehabilitation therapy provider, we appreciate this opportunity to identify specific recommendations that if adopted would improve coordinated care for Medicare and dual eligible beneficiaries who because of their chronic conditions require facility-based care delivery.

Genesis Healthcare employs over 80,000 healthcare workers in 475 post-acute and long term care facilities across 30 states, and through our subsidiary, Genesis Rehabilitation Services (GRS), provide therapy services (PT, OT & SLP) in over 1,700 locations in 45 states and the District of Columbia. Additionally we operate Genesis Healthcare ACO, a subsidiary which employs hundreds of physicians and nurse practitioners who attend to residents in many of our care centers. Collectively, our caregivers meet the needs of over 300,000 people annually.

Genesis Healthcare ACO is participating in the Medicare Shared Savings Program (MSSP) today piloting its delivery to Medicare beneficiaries residing in long term care facilities. Our MSSP ACO patients are nearly all institutionalized, receiving long-term care in our nursing homes. Their average age is 79 and median age is 82, with a high prevalence of medical comorbidities and dementia. The median length of stay is under 2 years, prior to death. Over 94 percent of our attributable ACO patients live their remaining months and years within our centers without ever

being discharged back to the community setting. Our experience demonstrates that access to consistent, patient-centered medical care improved quality outcomes and meaningful cost savings. Our ability to continue to demonstrate the significant potential savings that exist through this program for Medicare's costliest population hinges on the immediate resolution of several policy issues.

➤ **Enhanced Physician and Nurse Practitioner Engagement Offer Significant Opportunities to Transform Medical Care Delivery for Long Term Care Residents Living in Nursing Facilities:**

Our experiences underscore that enhanced physician and nurse practitioner engagement and improved care coordination delivered through Accountable Care Organizations participating in the Medicare Shared Savings Program (MSSP) offer significant opportunities to transform medical care delivery for long term care residents living in nursing facilities. Unlike other programs that target the dual eligible population, which are primarily focused on expanding community based supports to enable Medicare beneficiaries to remain at home longer, or the chronically-ill population, which have greater potential at earlier stages of disease progression, the MSSP can serve to better address the complex needs of Medicare beneficiaries residing in long-term care settings and reduce Medicare spending.

The Medicare Shared Savings Program rewards providers to lower cost against benchmarks, initially established based on their own historical performance before comparison to wider regional benchmarks, provide ample opportunity for widespread physician and nursing facility participation and should begin to reduce unnecessary hospital admissions of long term care residents, reduce their lengths of stay while in the skilled setting and improve quality outcomes.

➤ **Current MSSP Program Requirements are Barriers to Successful Implementation:**

While the MSSP was not specifically designed for this population, it can largely fulfill its objectives with several modifications to program requirements and with the accurate

determination of program benchmarks against which shared savings are determined. We have articulated these concerns to officials of the Centers for Medicare and Medicaid Services (CMS).

- **Inappropriate Quality Metrics**

Two MSSP Quality Measures address interventions that are medically inappropriate for the population living in long term care facilities: PREV-5 for Breast Cancer Screening and PREV-6 for Colorectal Cancer Screening. In both cases, recommendations and guidelines from specialty medical organizations recommend AGAINST these measure for patients with life expectancies under 10 years. Other Quality Measures may have applicability on a patient-specific basis, but the metric definitions don't fully account for shared decision-making between the physician and the patient or family. Current ACO rules should be modified to allow for long term care patients to be excluded from measurement.

- **Inapplicability of CAHPS Survey Process**

ACOs like ours, which are almost entirely comprised of long-term nursing home residents, are faced with an illogical situation in the administration of CAHPS within the MSSP. CAHPS results drive eight Quality Measures and the entirety of one of four required domains, Patient/Caregiver Experience, yet the survey cannot be administered in our care setting. CAHPS specifications specifically exclude institutionalized patients such as nursing home residents, leaving only six (6) percent of our total attributed beneficiaries to be mailed the survey. This approach results in the likelihood of extremely low sample size of responses and statistical insignificance. Furthermore, those sampled are entirely non-representative of our ACO population that reside in the long-term care setting, and will not likely associate the care they received during their nursing facility stay with their primary care. The implications of this inappropriate approach to garnering customer satisfaction with the delivery of primary care in our ACO, especially the potential for extremely low results on the CAHPS survey, may disqualify our ACO from any shared savings altogether, regardless of financial performance and achievement of quality performance on other measures.

CMS's use of CAHPS by reference is not mandated by statute or regulation; law and regulations are general about what needs to be measured and does not dictate any specific survey tool. CMS

has the options of a de minimis cut-point so that CAHPS would only be required when a significant portion of the ACO population is eligible to receive the survey. The agency also could consider a substitution of a validated survey of nursing home residents which assesses similar issues of provider access and experience intended by the current survey in lieu of the use of the CAHPS tool.

- **Inaccurate Benchmarks**

Place of Service (POS) codes on health care professional claims indicate the setting where the service was provided. Physician visits to patients in skilled nursing facilities which serve both short-stay patients who return home and long-term residents of the facility must determine if the patient is currently under a Medicare Part A stay, in which case POS 31 is to be used, while custodial patients are assigned POS 32. Differential payment rates between 31 and 32 ceased in 2006, though this vestige of the obsolete reimbursement method remained. A 2015 OIG investigation on behalf of HHS found that significant overpayments to physicians due to inaccurate place-of-service coding, in that case between inpatient and outpatient locations, resulted from “internal control weaknesses at the physician billing level and to insufficient post payment reviews at the Medicare contractor level to identify potential place-of-service billing errors”¹.

CMS eliminated primary care services provided to short-stay patients in skilled nursing facilities for attribution and the creation of benchmarks for MSSP beginning in 2017, it identified these patients using POS coding on physician claims, not the more accurate Medicare facility claims. Physician claims used for establishing benchmarks date back three years prior to the MSSP participant’s initial performance period. The inaccuracy of the benchmark data distort performance benchmarks and undermines the opportunities for shared savings. And, as benchmarks remain in place for the full three-year MSSP agreement period, the impact of these inaccuracies is compounded. There is no regulatory authority for Medicare contractors to allow the correction of administrative errors that may have existed to ensure accurate benchmark calculations.

¹ <https://oig.hhs.gov/oas/reports/region1/11300506.pdf>

➤ **Navigating a Successful Transition to Value-Based Care:**

Our company and the post-acute provider sector face significant pressures as a result of broader market change and the adoption of value-based care. Nevertheless, Genesis understands the value of these systemic changes. We have chosen to actively participate in alternative payment models and care delivery redesign. We believe that the development of new delivery systems to improve outcomes and efficiencies are fundamentally necessary for our long-term success and the success of the healthcare system. Navigating a successful transition from fee-for-service (“FFS”) to population health management has become a lynchpin of Genesis’s strategy and success.

For additional information please contact Jason Feuerman, President, Genesis Healthcare ACO, LLC at 612-612-5678 (via email at Jason.Feuerman@genesishcc.com.) or Laurence F. Lane, VP, Government Relations, Genesis Healthcare Inc. at 610-444-8430 (via email at Laurence.Lane@Genesishcc.com.).



June 9, 2017

The Honorable Pat Tiberi
 Chairman
 Subcommittee on Health
 Ways and Means Committee
 United States House of Representatives
 Washington, D.C. 20515

Dear Chairman Tiberi:

Thank you for your leadership on the Medicare Advantage (MA) program. As the Subcommittee on Health prepares to hold a hearing, the Healthcare Leadership Council (HLC) welcomes the opportunity to share our thoughts with you.

HLC is a coalition of chief executives from all disciplines within American healthcare. It is the exclusive forum for the nation's healthcare leaders to jointly develop policies, plans, and programs to achieve their vision of a 21st century healthcare system that makes affordable, high quality care accessible to all Americans. Members of HLC – hospitals, academic health centers, health plans, pharmaceutical companies, medical device manufacturers, laboratories, biotech firms, health product distributors, pharmacies, post-acute care providers, and information technology companies – are committed to advancing a consumer-centered healthcare system that values innovation, accessibility, and affordability.

MA currently serves 19 million beneficiaries (33% of the Medicare population) and this group continues to grow. MA plans appeal to new beneficiaries because MA often resembles their previous employer-sponsored health insurance that provided catastrophic coverage and care coordination. MA plans give beneficiaries choice, accessibility, care coordination, and disease management tools, particularly for beneficiaries with multiple chronic conditions. HLC urges the Subcommittee to consider the following proposals that will strengthen this important program and enable MA to continue to be an affordable and high quality choice for Medicare beneficiaries.

Special Needs Plans (SNPs)

HLC asks the Subcommittee to permanently reauthorize the SNPs. These plans serve an important role for beneficiaries who are high-risk. SNPs allow beneficiaries access to care plans and provider networks designed especially for their health conditions. Making the program permanent would encourage broader replication of best practices and care delivery. HLC also recommends that the Subcommittee support legislation similar to the bill introduced in the last Congress (H.R. 4212, the "Community-Based Independence for Seniors Act"). This bill would create a Community-Based Institutional Special Needs Plan (CBI-SNP) demonstration program that would provide home and

community based services (HCBS) to low-income Medicare beneficiaries who are unable to perform two or more activities of daily living. This program would improve care and eliminate the need for these beneficiaries to spend down their income and assets to qualify for Medicaid. They would instead be provided with home and community-based long-term care services and supports.

Program of All-Inclusive Care for the Elderly (PACE)

HLC supports the PACE program, which coordinates care for frail, elderly individuals, most of whom are dually eligible for Medicare and Medicaid. The comprehensive medical and social services offered by this program enable PACE individuals to remain in the community. Payments under the program are capitated, which allows an interdisciplinary team of providers to deliver all of the services participants need rather than limit them to the services provided under fee-for-service (FFS) plans.

Telehealth Services

HLC believes that telehealth is an important tool to modernize the healthcare system, and supports waiving Medicare's geographic and technical limitations on the use of telehealth. The capitated payment structure in MA is well-suited to incentivize telehealth innovations. The basic benefit package for MA should include telehealth, and this benefit should not be limited to the amount of supplemental funds available.

Value-Based Insurance Design (VBID)

HLC is supportive of VBID structures that incentivize beneficiaries to use high-value services. MA plans should have the ability to offer incentives (for example, lower cost-sharing) for beneficiaries that use certain health services. These types of incentives engage patients in their care and lead to higher levels of compliance with healthcare recommendations.

Alternative Payment Models (APMs)

APMs under the MA program provide a higher level of care coordination and better outcomes. The Subcommittee should level the playing field between traditional Medicare and MA by giving physicians equal incentives to take part in an APM under MA.

Social Determinants of Health

HLC urges the Subcommittee to support policies that adjust for the social determinants of health of Medicare beneficiaries. As recommended by the National Academies of Sciences, Engineering, and Medicine (NASEM), HLC believes that Medicare payments should be adjusted for social risk factors. The academies identified four approaches that could be used to account for these social risk factors, including stratified public reporting by risk factors to identify which providers are serving these patients, adjustment of performance measures to standardize estimates of quality, adjustment of payments to providers, and the restructuring of payment incentives to reward improvement in quality or achievement of high-value care.¹ HLC agrees with NASEM

¹ National Academies of Science, Engineering, and Medicine, Accounting for Social Risk Factors in Medicare Payment (Washington, DC: National Academies Press, 2017).

that a combination of these methods, including changes to both public reporting and Medicare payments, would best account for the social determinants of health of Medicare beneficiaries. MA plans should be allowed to offer a wide array of supplemental benefits to address these social determinants, including nonmedical services such as transportation to medical appointments and access to healthy foods. The Subcommittee should encourage the use of Community Health Workers (CHWs) to link MA beneficiaries to these services.

Pilot Program

The Subcommittee should also encourage the Centers for Medicare and Medicaid Services (CMS) to test a new value-based payment and coordinated care delivery model for Medicare's sickest and costliest beneficiaries. This pilot would allow the most highly qualified MA plans and accountable care organizations (ACOs) to deliver integrated and coordinated care to the neediest beneficiaries.

Benchmark Cap

HLC urges the Subcommittee to acknowledge the work of MA plans with high star ratings by supporting legislation (H.R. 908, the "Medicare Advantage Quality Payment Relief Act") that would remove the benchmark cap. In 2016, the cap on benchmarks affected 72% of MA beneficiaries in plans with 4 or more stars and reduced the available bonus payments to those plans. This cap reduces incentives for MA plans to continuously improve the care they provide to their beneficiaries.

Thank you again for your work on the MA program. HLC looks forward to continuing to collaborate with you on this important issue.

Sincerely,



Mary R. Grealy
President

National
MLTSS
Health Plan Association

House Committee on Ways and Means, Subcommittee on Health
Testimony of G. Lawrence Atkins, PhD
Executive Director, the National MLTSS Health Plan Association
June 7, 2017

Chairman Tiberi, Ranking Member Levin, and Members of the Subcommittee:

Thank you for the opportunity to provide testimony on promoting integrated and coordinated care and services for Medicare beneficiaries. We want to commend the Committee on its attention to this most important area of focus.

My name is Larry Atkins and I am the Executive Director of the National MLTSS Health Plan Association. Members of the Association are managed care organizations that contract with state Medicaid programs to provide managed long-term services and supports (MLTSS). Across 18 states, our members enroll nearly a million members in MLTSS plans and 175,000 members in Medicare-Medicaid plans (MMPs) through CMS's Financial Alignment Initiative (FAI). Together, we account for about 70 percent of the MLTSS market and about half of the MMP enrollment.

As health plans specializing in managing long-term services and supports (LTSS) for state Medicaid programs, we have been successful in helping individuals with functional needs and their families attain their goals through obtaining the assistance they need. Our work helps states achieve their objectives of rebalancing and integrating beneficiaries in the community, and managing Medicaid expenditures.

As we work toward those goals, we aim to improve our success through opportunities to engage in fully-integrated programs – particularly for Dual Eligible beneficiaries -- where we can bring Medicare's medical spending and Medicaid's LTSS spending together to provide fully integrated and coordinated care for the individual.

Today I would like to discuss the importance of integrating and coordinating care and services, the key role that LTSS plays in integration, and our thoughts on how to improve our current programs for integration.

Fully-integrated approaches that streamline and coordinate care and services for persons with disabilities and older adults covered under Medicaid, or under Medicare and Medicaid, improve the accountability to consumers and states for quality and outcomes and access to care and services, while better managing cost for states, and achieving greater efficiency and sustainability. Our experience with integrated models reflects that consumer satisfaction with integrated care is high and integrating LTSS with medical care helps reduce medical spending for beneficiaries with complex care needs. For example, member satisfaction surveys in CMS's Financial Alignment Demonstration show that more than half of consumers receiving care through an MMP rated the quality of their health plan a 9 or 10 out of 10 and 80% of health plans received at 7 out of 10 or higher¹. In addition, a recent study of Minnesota's integrated plans (MN Senior Health Options (MSHO)) found that enrollees were half as likely to have a hospital admission and less likely to have an ER visit than enrollees in non-integrated Medicaid plans (MN Senior Care Plus (MSC+)).²

LTSS is a critical component of care for Dual Eligibles. More than 40 percent of dual-eligible beneficiaries rely on LTSS³ and Duals who need LTSS have much higher levels of medical spending than those who don't: total spending for dual-eligible beneficiaries increases anywhere from 2 times to 4.5 times if the individual relies on any kind of LTSS, including nursing home care and home- and community-based services (HCBS)⁴.

Fully-integrated models are still only available to a small portion of the Dual Eligible population. The Program for All-inclusive Care of the Elderly (PACE) is the longest-standing fully-integrated program. It is a model that has worked well for older adults with complex-care needs, although it has only been able to enroll a small number of them. It is not well-suited for persons with disabilities under age 65.

The Duals Special Needs Plans (D-SNPs) and Fully-Integrated Dual Eligible SNPs (FIDE-SNPs) have provided a greater opportunity to expand coverage under an integrated approach, but these

¹ "Enrollee Experiences in the Medicare-Medicaid Financial Alignment Initiative: Results from the 2015 CAHPS Survey." Centers for Medicare and Medicaid Services. Apr. 2016. Web. <<https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/FAICAHPSResultsApr2016.pdf>>

² WL Anderson, Z Feng and S Long. Minnesota Managed Care Longitudinal Analysis. ODAL/ASPE/DHHS, March 2016. Enrollees in Minnesota's integrated plans (MN Senior Health Option (MSHO)) were:
- 48 percent less likely to have a hospital stay, and if so, had 26 percent fewer stays than enrollees in a non-integrated plan
- 6 percent less likely to have an outpatient ED visit, and if so, had 38 percent fewer visits than enrollees in a non-integrated plan

³ "Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid." MedPAC & MACPAC, Jan. 2017. Web. <https://www.macpac.gov/wp-content/uploads/2017/01/Jan17_MedPAC_MACPAC_DualsDataBook.pdf>.

⁴ *Ibid*

approaches require alignment with a Medicaid MLTSS plan – which is difficult to achieve with just a D-SNP.

The Financial Alignment Initiative’s Medicare and Medicaid Plans (MMPs) are the most fully integrated, but are only operating under a demonstration authority that expires in a few years.

For integrated care to become available in a meaningful way for the population of Dual Eligibles that would benefit tremendously from it, Congress will need to act to reauthorize and expand existing programs and to enable the creation, on a permanent basis, of a more universal approach to integrated care.

In the immediate future, Special Needs Plans (SNPs) in all forms, which are currently authorized only through December 31, 2018, should be permanently authorized. In addition, the FIDE-SNP, which aligns Medicare and Medicaid, should be encouraged as an important model for Dual Eligibles, while maintaining the option for states to choose to contract with D-SNPs that may not have reached FIDE-SNP status. Upon completion of the FAI demonstration, MMPs should be permanently extended, with opportunities for states to launch new MMPs.

PACE should have the ability to expand the model’s capacity to serve older adults with disabilities. As changes are made to PACE that make it more generally attractive, it will come to resemble other integrated managed care plans. As it does, it should come under the consumer protections that apply for these other integrated models, including marketing and network adequacy requirements.

There are challenges in trying to expand coverage for Dual Eligibles under integrated approaches. The most significant have been the challenges in aligning their Medicare and Medicaid coverage, and getting high rates of participating in fully-aligned models.

Where states have MLTSS plans and D-SNPs and may require organizations providing MLTSS to also offer a D-SNP plan, it has been difficult to get beneficiaries enrolled in the MLTSS and Medicare plan (MA or D-SNP) of the same organization. The choice that Duals have of Medicare coverage (fee-for-service, MA, or SNP) often results in Duals having different Medicare and Medicaid coverage, which makes it difficult for plans to coordinate care and achieve the outcomes and health care savings of an integrated model.

For fully-aligned models, states have experimented with both voluntary enrollment and passive enrollment with an opt out. Some states have been quite successful with enrollment, but in

general enrollment in fully integrated plans remains below optimal levels, and more work is needed to encourage or enable higher levels of enrollment.

Eventually, all eligible Medicaid beneficiaries should be afforded the benefits that come with full integration of LTSS and Medicare. States should have the option of creating a requirement for eligible individuals to be in a Medicare product that is fully integrated - whether it is a health plan product (e.g., MMP, DSNP, MA), PACE, ACO, or some other new modality. Consumers should have the choice of modality and, of course, choice within the modality.

As we look to the future, we believe a common framework should emerge for all arrangements through which organizations take broad capitated risk (e.g., for medical and non-medical services) – a framework that would allow for a variety of modalities⁵ to fit the unique needs of individual beneficiaries in different circumstances. The framework should:

- Apply to all plans that integrate and hold financial risk for medical, behavioral health, LTSS and other non-medical services and supports;
- Provide for payments to these plans that combine all applicable federal and state Medicare and Medicaid funds through a single payment determination and administration process that provides for pooling and sharing of overall savings between the state, federal government and the plan;
- Incorporate financial performance measures that create accountability to government payers for managing costs, for achieving state and federal payer goals of rebalancing, reducing institutionalization, readmissions to hospital and institutional settings, and reducing avoidable episodes of care;
- Provide for accountability to government payers and consumers and their families through performance measures that speak to progress toward consumer satisfaction and quality of life, and societal goals of reduction of health disparities, impact on social determinants of health, and rebalancing among settings and effective community integration;

⁵ Modalities would include current varieties: Program for All-Inclusive Care for the Elderly (PACE), Medicare-Medicaid Plans (MMPs), Fully-Integrated Dual Eligible Special Needs Plans (FIDE-SNPs), Dual Special Needs Plans (D-SNPs), Medicaid Managed LTSS (MLTSS) plans, Accountable Care Organizations (ACOs) and Medicare Advantage (MA) plans that take risk for LTSS, and other possible varieties of plan.

- Allow broad benefit flexibility to provide services that best meet the unique and varied individual needs of consumers through “In Lieu of Services” that may be specified in statute or regulation; and
- Provide a consistent standard for care coordination and the resulting care and service plans across Medicare and Medicaid programs, with the Person-Centered service planning process as the gold standard.

In conclusion, we urge the Committee to approve legislation to permanently reauthorize all SNP types. We further encourage the Committee to continue to work on ways to advance the most fully-integrated approaches to serve all consumers who need LTSS, and would like to work with Members of the Committee on legislative proposals that could enhance integration opportunities in the future.



STATEMENT FOR THE RECORD
WAYS AND MEANS HEALTH SUBCOMMITTEE

Medicare Advantage Hearing on Promoting Integrated and Coordinate Care for Medicare Beneficiaries
June 7, 2017

Coordination is crucial for the proper care and treatment of Medicare beneficiaries, as they frequently face simultaneous conditions, see various providers and take multiple prescription drugs. Care coordination is at the heart of Accountable Care Organizations' (ACOs) abilities to successfully provide population health management, resulting in healthier outcomes, higher quality and lower costs. The National Association of ACOs (NAACOS) is grateful to Chairman Tiberi for examining this crucial issue and hopes other alternative delivery system models will have the opportunity to highlight the successes and challenges facing beneficiaries and providers in care coordination.

While ACOs use patient care managers and electronic health records as two tools for care coordination, the ability to be reimbursed by Medicare for telehealth services and remote patient monitoring for all ACO models would be an enormous step towards enhancing patient safety, improving health outcomes and quality of care, and reducing costs.

ACOs represent a refined approach to the delivery of health care and were created through a bipartisan effort to facilitate coordination and cooperation among providers to improve the quality of care and to reduce unnecessary costs. ACOs are the type of model that Congress intended to support through MACRA, and we have urged CMS to further support the ACO model so that it may achieve long-term success as a leading Medicare APM.

As a market-based solution, ACOs rely on groups of physicians, hospitals, and other providers voluntarily collaborating to achieve these important goals. As of 2017, there are 525 Medicare ACOs serving more than 10 million beneficiaries (approximately 20% of Medicare enrollees) with hundreds more commercial and Medicaid ACOs serving millions of additional patients.

The accountable care model has a long history of bipartisan support, starting with the Physician Group Practice Demonstration Program passed under President George W. Bush's administration in 2000 and further expanded under President Obama's administration. ACOs are proving to be one of the most promising solutions to bend the cost curve and provide high-quality patient care and are a premier payment model in the shift to value-based care.

NAACOS is the largest association of ACOs, representing over 3.5 million beneficiary lives through over 230 Medicare Shared Savings Program (MSSP) ACOs, Next Generation, and commercial ACOs. NAACOS is an ACO member-led and member-owned non-profit organization that works on behalf of ACOs across the nation to improve the quality of Medicare delivery, population health and outcomes, and health care cost efficiency. Our members, more than many other healthcare organizations, want to see an effective, coordinated patient-centric care process. It is our desire to see ACOs achieve the long-term sustainability necessary to enhance care coordination and health outcomes for Medicare beneficiaries, reduce healthcare costs, and improve quality in the Medicare program.

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PACE Organizations Across the Country

Current as of March 1, 2017 (122 organizations in 31 states)

	PACE Organization	City
AL	Mercy LIFE of Alabama	Mobile
AR	Complete Health with PACE	North Little Rock
	Total Life Healthcare	Jonesboro
CA	Altamed Senior BuenaCare	Los Angeles
	Brandman Centers for Senior Care	Reseda
	CalOptima	Orange
	Center for Elders' Independence	Oakland
	Fresno PACE	Fresno
	InnovAge of Greater California	San Bernardino
	On Lok Lifeways	San Francisco
	Redwood Coast PACE	Eureka
	San Diego PACE	San Diego
	St. Paul's PACE	San Diego
	Sutter SeniorCare PACE	Sacramento
CO	InnovAge of Greater Colorado	Denver
	Rocky Mountain PACE	Colorado Springs
	Senior CommUnity Care	Montrose
	TRU Community Care	Lafayette
DE	Saint Francis LIFE	Wilmington
FL	Florida PACE Centers	Miami
	Hope PACE	Fort Myers
	Palm Beach PACE	West Palm Beach
	Suncoast PACE, Inc.	Clearwater
IN	Franciscan Senior Health & Wellness	Indianapolis
	Saint Joseph PACE	Mishawaka
IA	Immanuel Pathways	Council Bluffs
	Siouxland PACE	Sioux City
KS	Bluestem PACE	Newton
	Midland Care PACE	Topeka
	Via Christi HOPE	Wichita
LA	PACE Baton Rouge	Baton Rouge
	PACE Greater New Orleans	New Orleans
MD	Hopkins ElderPlus	Baltimore
MA	East Boston Elder Service Plan	East Boston
	Elder Service Plan of Harbor Health Services	Mattapan
	Elder Service Plan of the Cambridge Health Alliance	Cambridge
	Element Care	Lynn
	Mercy LIFE of Massachusetts	Holyoke

	Serenity Care	Springfield
	Summit ElderCare	Worcester
	Upham's Elder Service Plan	Boston
MI	Care Resources	Grand Rapids
	CentraCare	Battle Creek
	Genesys PACE of Genesee County	Flint
	Great Lakes PACE	Saginaw
	Huron Valley PACE	Ypsilanti
	Life Circles	Muskegon
	PACE Southeast Michigan	Detroit
	PACE of Southwest Michigan	St. Joseph
	Senior CommUnity Care of Michigan	Lansing
	Thome PACE	Jackson
NE	PACE Nebraska	Omaha
NJ	Beacon Health and Social Services	Oceanport
	Inspira LIFE	Vineland
	LIFE at Lourdes	Pennsauken
	LIFE St. Francis	Trenton
	Lutheran Senior LIFE	Jersey City
NM	InnovAge of Greater New Mexico	Albuquerque
NY	ArchCare Senior Life	New York
	Catholic Health – LIFE	Buffalo
	CenterLight Healthcare	Bronx
	Complete Senior Care	Niagara Falls
	Eddy SeniorCare	Schenectady
	ElderONE	Rochester
	Fallon Health Weinberg	Amherst
	PACE CNY	North Syracuse
	Total Senior Care	Olean
NC	CarePartners PACE	Asheville
	Carolina Senior Care	Lexington
	Elderhaus	Wilmington
	LIFE St. Joseph of the Pines	Fayetteville
	PACE @ Home, Inc.	Newton
	PACE of the Southern Piedmont	Charlotte
	PACE of the Triad	Greensboro
	Piedmont Health SeniorCare	Burlington
	Randolph Health StayWell Senior Care	Asheboro
	Senior CommUnity Care of North Carolina	Durham
	Senior Total Life Care	Gastonia
ND	Northland PACE	Bismarck
OH	McGregor PACE	Cleveland Heights
OK	Cherokee Elder Care	Tahlequah
	LIFE PACE	Tulsa
	Valir PACE	Oklahoma City
OR	Providence ElderPlace	Portland

PA	Albright LIFE	Lewisburg
	Community LIFE	Pittsburgh
	LIFE Armstrong County	Kittanning
	LIFE Beaver County	Aliquippa
	LIFE Butler County	Butler
	LIFE Geisinger	Danville
	LIFE NWPA	Erie
	LIFE Pittsburgh	Pittsburgh
	LIFE St. Mary	Feasterville Trevose
	Mercy LIFE – Philadelphia	Philadelphia
	Mercy LIFE – Western Philadelphia	Philadelphia
	NewCourtland LIFE	Philadelphia
	SeniorLIFE Ebensburg	Ebensburg
	SeniorLIFE Greensburg	Greensburg
	SeniorLIFE Johnstown	Johnstown
	SeniorLIFE Lehigh Valley	Bethlehem
	SeniorLIFE Washington	Washington
	SeniorLIFE York	York
	SpiriTrust Lutheran LIFE	Chambersburg
RI	PACE Organization of Rhode Island	Providence
SC	GHS Senior Care	Greenville
	Palmetto SeniorCare	Columbia
	The Oaks PACE	Orangeburg
TN	Alexian Brothers Community Services	Chattanooga
TX	Bienvivir Senior Health Services	El Paso
	Silver Star PACE	Lubbock
	The Basics at Jan Werner	Amarillo
VA	AllCARE for Seniors	Cedar Bluff
	Blue Ridge PACE	Charlottesville
	Centra PACE	Lynchburg
	InnovAge Virginia PACE – Roanoke Valley	Roanoke
	InovaCares for Seniors	Fairfax
	Mountain Empire PACE	Big Stone Gap
	Riverside PACE	Newport News
	Sentara Senior Community Care	Norfolk
WA	Providence ElderPlace	Seattle
WI	Community Care	Milwaukee
WY	Wyoming PACE	Cheyenne



Reforming Medicare to Better Manage Seniors' Health Care

Statement for the Record

Devon M. Herrick, Ph.D.

Senior Fellow
National Center for Policy Analysis

“Medicare Advantage Hearing on Promoting Integrated and Coordinated Care for
Medicare Beneficiaries”

Committee on Ways & Means, Subcommittee on Health

United States House of Representatives

June 7, 2017

Chairman Tiberi, Ranking Member Levin, and committee members, thank you for the opportunity to submit comments about Medicare Advantage reforms that improve care for seniors. I am Devon M. Herrick, Ph.D., a health economist and senior fellow at the National Center for Policy Analysis (NCPA). We are a nonprofit, nonpartisan public policy research organization headquartered in Dallas, Texas.

Not long after Medicare was established in 1965, expenditures began to skyrocket. Whereas spending per Medicare beneficiary was \$385 in 1970, spending per beneficiary increased to \$12,210 annually by 2013.¹

Nearly one-third of health care spending occurs in a hospital. An additional 20 percent is spent on physician services, while 10 percent is spent on drug therapies.² If one considers physician bills while patients are in the hospital, and other associated inpatient costs, a back-of-the-envelope calculation suggests nearly half of health spending occurs while patients are hospitalized, about to be hospitalized and while recuperating after an inpatient stay. Thus, it is increasingly clear that controlling costs means keeping chronically-ill seniors out of hospitals. To be effective, efforts to slow the growth in Medicare spending will have to focus on reducing hospital spending on beneficiaries in poor health by better managing their medical conditions.

To Reduce Costs, Focus on Big Spenders. It has long been known that:³

- A mere 20 percent of patients consume about 80 percent of health care resources;
- The sickest 10 percent cost constitute about two-thirds of health care spending;
- About 5 percent of patients spend half of health care dollars.
- The sickest 1 percent consume nearly one-quarter (22 percent).

If the sickest 5 percent of patients spend half of health care dollars, that means that 95 percent of patients are responsible for the remaining half. Indeed, the healthiest 50 percent of the population only consumes 3 percent of health care dollars. Furthermore, one quarter of Medicare spending is on the 5 percent of beneficiaries who are in their last year of life. These figures suggest there are more opportunities to reduce health care spending by carefully managing the

¹ David Blumenthal, Karen Davis and Stuart Guteman, "Medicare at 50 — Origins and Evolution," *New England Journal of Medicine*, Vol. 372, No. 5, January 29, 2015, pages 479-486.

² "National Health Expenditures 2015 Highlights," Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, undated. Available at: <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/downloads/highlights.pdf>.

³ "The High Concentration of U.S. Health Care Expenditures," Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services, Research in Action No. 19, AHRQ Pub. No. 06-0060, June 2006.

sickest 5 percent rather than wasting effort on the 95 percent who are relatively healthy. A significant portion of the big spenders are Medicare beneficiaries ages 65 to 79.⁴

Problem: Chronic Disease. Three chronic conditions account for 20 percent of total health expenditures: heart disease, pulmonary conditions and mental disorders. Spending is especially concentrated among chronically ill Medicare beneficiaries.⁵

There are numerous conditions that could be better managed to reduce costly interventions. According to CMS, more than half of beneficiaries in fee-for-service Medicare have high blood pressure, while nearly that many have high cholesterol. Nearly one-third have ischemic heart disease, while 6 percent are suffering from heart failure. More than one-fourth have diabetes, and a similar number have arthritis.⁶

Successful efforts to improve health and reduce costs necessarily must focus on the big spenders — those with multiple chronic conditions. Many beneficiaries using traditional, fee-for-service Medicare have multiple chronic conditions.⁷

- One-third of enrollees in fee-for-service Medicare have two or three chronic conditions.
- Nearly one-fourth have four or five chronic conditions.
- Fourteen percent have six or more.

As the number of chronic conditions rises, so does the likelihood of being admitted to a hospital during the year. Having multiple chronic conditions also boosts the likelihood of an ER visit, and a readmission.⁸ Medicare spending also rises as a function of the number of an enrollee's chronic conditions. Thus:

- The one-third of beneficiaries in fee-for-service Medicare who suffer from four or more chronic conditions account for 90 percent of Medicare hospital readmissions, and three-quarters of total Medicare spending.
- Medicare fee-for-service enrollees with four to five chronic conditions spend 25 percent more than average.
- Those in fee-for-service Medicare with six or more conditions spend 235 percent more than average.⁹

⁴ Ibid.

⁵ "The High Concentration of U.S. Health Care Expenditures," Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services, Research in Action No. 19, AHRQ Pub. No. 06-0060, June 2006.

⁶ "Chronic Conditions among Medicare Beneficiaries," Chartbook: 2012 Edition, Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, 2012

⁷ Ibid.

⁸ Ibid.

⁹ Ibid.

Where Hospital Spending Occurs. The phrase “continuum of care” is sometimes used to describe the diverse settings where medical care is delivered at varying levels of intensity — each with a different cost. For example, after self-care with over-the-counter drugs, the doctor is the second line of defense against illness in the continuum of care. A patient experiencing chest pains unable to get in to see his or her doctor on short notice may present at the hospital Emergency Department (ED). If the patient’s condition is very serious, they may then be admitted to a hospital intensive care unit (ICU). Once stabilized, the patient moves from the ICU to a standard patient room on an acute care floor of the hospital. As the patient’s condition improves, they may be transferred to a skilled nursing facility to convalesce or to a rehab facility for intensive therapy.

Once patients are well enough to leave the hospital but too ill to convalesce at home, they may be transferred to a nursing home for a few days. Finally, when they are well enough, the patient will leave the nursing home and be sent home under the care of their primary care physician — and possibly provided with periodic home care by a visiting nurse. The continuum of care can involve numerous different settings, each providing a different level or type of care. The reason for differing levels of care in the care continuum is to take advantage of efficiencies that exist in one environment compared to another. Care provided in the wrong setting (for example, a hospital stay when home care would have sufficed) is one way the health care system wastes money. However, a problem with having many different silos of care — each with different attending physicians — is that care coordination among providers is often neglected to the detriment of the patient. Coordinated care not only creates the opportunity to improve health status but also, if properly done, saves money.

Problem: Poor Quality Care Transitions. When patients’ care shifts from one setting to another it is often referred to as “care transitions.” In a study of Medicare-age seniors, 22 percent of seniors observed made an average of one care transition per year — usually an admission to a hospital or a discharge from one.¹⁰ Poorly managed care transitions are very costly. Inadequate care coordination during the transition phase wastes an estimated \$25 billion to \$45 billion annually.¹¹ Often, when seniors are discharged from the hospital they are not provided with appropriate post-discharge care. Without appropriate care after leaving the hospital, many get worse and have to be readmitted. This happens to be the case with many patients.¹²

- One-in-five seniors who are discharged from a hospital are readmitted within 30 days.
- More than one-third of Medicare hospital discharges are readmitted within 90 days, while more than half will return within a year.

¹⁰ Masayo Sato et al., “Residential and Health Care Transition Patterns Among Older Medicare Beneficiaries Over Time,” *The Gerontologist*, Vol. 55, No. 4, August 2015.

¹¹ Rachel Burton et al., “Care Transitions,” *Health Affairs*, Health Policy Brief, September 13, 2012. Available at http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=76.

¹² Steven F. Jencks, Mark V. Williams and Eric A. Coleman, “Rehospitalizations among Patients in the Medicare Fee-for-Service Program,” *New England Journal of Medicine*, No. 360, No. 14, April 2, 2009, pages 1418-1428.

An estimated three-fourths of Medicare readmissions could be prevented with proper transitional care. And that's not all:

- About one-in-seven seniors who are discharged from the hospital visit a hospital emergency room within 30 days of discharge;
- Indeed, more than 10 percent of Medicare discharges are readmitted through the emergency department.¹³

The exact cause of unnecessary Medicare hospital readmissions is the subject of much research and intensive debate. Increasingly, hospitals employ physicians trained as hospitalists. Some experts fear the growing use of hospitalists impedes the active participation of Medicare patients' own physicians in hospital rounds, and hampers continuity of care once a senior is discharged from the hospital.¹⁴ To be sure, hospitalists work for the hospital and are not in a position to coordinate seniors' care post discharge. Physicians complain that communication between hospitalists and seniors' primary care providers is poor following hospital stays.¹⁵ During transitions from one care setting to another, seniors' physicians are often not notified and do not receive medical records necessary for follow-up care in a timely manner.¹⁶ About half of seniors readmitted within one month did not even see their doctor between their discharge and readmission.¹⁷

If a Medicare inpatient's own physician was the attending physician, post-discharge care would possibly be more seamless. Yet, doctor-patient communication in general could also use improvement. In one study, three-fourths of physicians did not bother to inform patients when the results of diagnostic tests were normal.¹⁸ Nearly one-third did not contact patients when results were abnormal. Other studies found that patients did not understand the instructions given to them by their physicians about half the time.¹⁹ The blunt reality is that primary care physicians

¹³ Keith E. Kocher et al., "Emergency Department Visits After Surgery are Common For Medicare Patients, Suggesting Opportunities To Improve Care," *Health Affairs*, Vol. 32, No. 9, September 2013, pages. 1,600-1,607.

¹⁴ Hoangmai H. Pham et al., "Hospitalists and Care Transitions: The Divorce of Inpatient and Outpatient Care," *Health Affairs*, Vol. 27, No. 5, September 2008, pages 1,315-1,327.

¹⁵ Christine D. Jones, "A Failure to Communicate: A Qualitative Exploration of Care Coordination Between Hospitalists and Primary Care Providers Around Patient Hospitalizations," *Journal of General Internal Medicine*, Vol. 30, No. 4, April 2015, Volume 30, pages 417-424.

¹⁶ Ibid.

¹⁷ Stephen F. Jencks, Mark V. Williams and Eric A. Coleman, "Rehospitalizations among Patients in the Medicare Fee-for-Service Program," *New England Journal of Medicine*, Vol. 360, No. 14, April 2, 2009, pages 1,418-1,428.

¹⁸ Tejal K. Gandhi, "Fumbled Handoffs: One Dropped Ball after Another," *Annals of Internal Medicine*, Vol. 142, No. 5, March 2005, pages 352-358.

¹⁹ Debra L. Roter, Judith A. Hall, "Studies of Doctor-Patient Interaction," *Annual Review of Public Health*, Vol. 10, 1989, pages 163-180. Also see Dean Schillinger et al., "Closing the Loop: Physician

are not sufficiently remunerated for their efforts to manage and coordinate the care their patients receive from other providers rendered in non-office settings.

Medical Homes and Care Coordinators. A medical home that coordinates care is an invaluable resource to seniors. For instance, a medical home coordinates care before, during and after the critical care transitions between a hospital and the follow up care post-discharge. A coordinator could advise seniors on lower-cost health care settings, evaluate the need for home care, and ensure seniors receive follow-up care and comply with drug therapy.

Consider the earlier example of a senior experiencing chest pains, but assume the symptoms are nausea that sometimes accompanies a heart attack. A call coordinator could advise the senior whether to immediately seek care at a hospital emergency department or a free-standing emergency room clinic. Depending on the symptoms, an urgent care clinic may be both more convenient and less expensive. If a condition does not warrant immediate care, a possible alternative to urgent care (or emergency care) is a retail clinic. A care coordinator might dispatch a nurse practitioner (or physician) in a van, or even assure a patient that waiting for an appointment with the affiliated primary care provider is more appropriate.

The setting where care is received matters. Hospital EDs are far more costly — and less convenient — than care received in other settings.²⁰ Furthermore, about 15 percent of people who present to a hospital ED are admitted to the hospital.²¹ The corresponding admission rate for patients visiting free-standing ERs is only 4 or 5 percent.²² This may partly be due to self-selection; individuals who perceive their condition as extremely serious may purposefully choose a hospital ED rather than a free-standing ER. However, it could also be due to hospitals' desire to fill patient beds.

According to one study, nearly 60 percent of Medicare ED visits resulted in a hospital admission in 2010.²³ ED visits account for approximately 2 percent of Medicare expenditures.²⁴

Communication with Diabetic Patients Who Have Low Health Literacy," *Archives of Internal Medicine*, Vol. 163, No. 1, January 2003, pages 83-90.

²⁰ Elayne J. Heisler and Nancy Leigh Tyler, "Hospital-Based Emergency Departments: Background and Policy Considerations," Congressional Research Service, December 8, 2014.

²¹ Derek DeLia and Joel Cantor, *Emergency Department Utilization and Capacity* (Robert Wood Johnson Foundation, 2009).

²² Mike Williams and Michael Pfeffer, "Freestanding Emergency Departments: Do They Have a Role in California?" California HealthCare Foundation, Issue Brief, 2009.

²³ Centers for Disease Control and Prevention, *Ambulatory Health Care Data: National Ambulatory Medicare Care Survey*, National Hospital Ambulatory Medicare Care Survey: 2010 Emergency Department Summary Tables, Hyattsville, MD, February 24, 2014, pages 6-7. Available at http://www.cdc.gov/nchs/data/ahcd/nhamcs_emergency/2010_ed_web_tables.pdf.

²⁴ Jeffrey M. Gonzalez, *National Health Care Expenses in the U.S. Civilian Noninstitutionalized Population, 2011*, Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey.

However the total is undoubtedly much higher when subsequent inpatient stays are added in. Sometimes seniors are admitted unnecessarily or merely for observation. When seniors are put in the hospital under “observation care” but not officially “admitted,” their cost-sharing is often high.²⁵ In some cases, emergency room doctors have complained about being pressured by hospital executives to admit patients, or being given a quota and told that a fixed percentage of emergency room patients should be admitted.²⁶ Inpatient admissions are where hospitals earn the bulk of their revenue. As a result, emergency room physicians are under pressure to find reasons to justify admissions. They are not generally rewarded for solutions that avoid costly hospital stays.

Better Care for Sick Seniors. Medical homes provide care coordination managed by patients’ primary care physicians, who oversees each patient’s care. However, nearly half of physicians now work for hospitals or other institutions. Physician employment by hospitals creates a conflict of interest that risks too much self-referral of costly hospital-provided services that may not be necessary.

Medical homes with staff supervised by primary care physicians can also advise seniors on where to find cost-effective services, whether they need a specialist and which specialist to see. For example, Medicare could save billions of dollars if all seniors were given an annual risk assessment and assigned a medical home to coordinate their care.

Done correctly, coordinated care reduces costs and improves quality. It can reduce the poking, prodding and radiating of patients who are often subjected to redundant medical tests. Coordinating Medicare patients’ care has shown the potential to save money by preventing complications or adding readmissions.

The ultimate goal is to achieve behavioral change among both patients and providers. A primary care provider must have the incentive to keep seniors healthy and out of the hospital. Specialists must have an incentive to communicate with patients care coordinators. Seniors must change the way they interact with the health care system. This means primary care providers (PCP) must be rewarded when they meet benchmarks and metrics that improve the health status of seniors. There are shared risk payment models, but they depend more on sticks than rewards of carrots. PCPs must be “at-risk” of losing their quality bonus, but not their fee-for-service reimbursements.

Statistical Brief No 425, November 2013. Available at http://meps.ahrq.gov/mepsweb/data_files/publications/st425/stat425.pdf.

²⁵ Susan Jaffe, “Medicare covers less when a hospital stay is an observation, not an admission,” *Washington Post*, September 8, 2014.

²⁶ “Hospitals: The cost of admission,” 60 Minutes, CBS News, December 3, 2012. Available at <http://www.cbsnews.com/news/hospitals-the-cost-of-admission-03-12-2012/>. Also see Bob Herman, “HMA: ‘60 Minutes Report Relied on Disgruntled Former Employees,’” *Becker’s Hospital Review*, December 3, 2012.

Physician Network Management. When Americans access the U.S. health care system, they typically seek the guidance of a gatekeeper — otherwise known as a licensed physician. The average Medicare beneficiary sees two primary care doctors and five specialists per year.²⁷

Seniors living with multiple chronic conditions may see more than a dozen different doctors.²⁸ About 90 percent of all seniors take a prescription drug in any given year.²⁹ Seniors with chronic ailments may take a dozen drugs or more on a daily basis. With the exception of over-the-counter drugs, patients must first consult with a doctor before beginning drug therapy, and often before refilling a prescription.

Just about everything that occurs within the continuum of care requires the authorization of a physician.³⁰ Doctors can be valuable in managing the cost and improving the health of Medicare populations. With few exceptions, health plans do not employ doctors directly. Insurers increasingly partner with physicians to provide the actual care and coordinate the care of other providers. Partnering with a well-managed physician network is the key to coordinating care, increasing quality and controlling costs.³¹ Physician networks can offer medical homes with a strong patient-provider relationship and a system of patient communication, significant training and support.³²

Conclusion

There are opportunities to reduce the growth in Medicare spending by carefully managing care for the sickest seniors. Increasingly, Medicare needs to use some of the other tools employed by private health plans. These include medical homes, care coordination and utilization management that rewards Medicare plans when they boost quality and lower costs.

Thank you for the opportunity to submit these written comments.

²⁷ Thomas Bodenheimer, “Coordinating Care — A Perilous Journey through the Health Care System,” *New England Journal of Medicine*, Vol. 358, No. 10, March 6, 2008.

²⁸ Hoangmai H. Pham et al., “Care Patterns in Medicare and Their Implications for Pay for Performance,” *New England Journal of Medicine*, Vol. 356, No 11, 2007, pages 1,130-1,139

²⁹ Agency for Healthcare Research and Quality, “Prescription Medicines-Mean and Median Expenses per Person with Expense and Distribution of Expenses by Source of Payment: United States, 2010,” Medical Expenditure Panel Survey Household Component Data. Available at <http://goo.gl/D0eNvT>.

³⁰ Nicholas Bonvicino and James Doulgeris, “High-performing Physician Networks: The Ideal ACO,” *Physicians Practice*, blog, January 17, 2013. Available at <http://www.physicianspractice.com/blog/high-performing-physician-networks-ideal-aco>.

³¹ Ibid.

³² Ibid.

Committee on Ways and Means
 Subcommittee on Health
 Medicare Advantage Hearing on Promoting Integrated and
 Coordinated Care for Medicare Beneficiaries
 June 7, 2017
 Statement for the Record

SCAN Health Plan (SCAN) would like to thank the Subcommittee for holding a hearing focused on the important role the Medicare Advantage (MA) program plays in promoting integrated and coordinated care for seniors. We welcome the opportunity to share our experience managing care for some of Medicare's most clinically complex beneficiaries and to offer our suggestions for improving the program.

SCAN is a not-for-profit health plan that serves seniors through MA plans and institutional, chronic care, and dual eligible special needs plans (SNPs). Approximately 185,000 Medicare beneficiaries are enrolled in SCAN's MA plans in California, making it the fifth largest not-for-profit MA prescription drug plan in the country. Since 1985, SCAN has specialized in providing comprehensive, high-quality care to the most vulnerable Medicare beneficiaries – those who live with multiple chronic conditions, those who are eligible for nursing home care, and those who experience difficulty performing activities of daily living. Medicare beneficiaries benefit from SCAN's partnerships with health care providers that engage with seniors to provide the right care at the right time, while maximizing their ability to maintain their independence.

SCAN is pleased to share several policy proposals that we believe will help expand on the MA program's success in delivering quality, coordinated care to Medicare beneficiaries.

Providing Continued Access to MA Special Needs Plans for Vulnerable Populations Since 2006, SNPs have proven their value in organizing care tailored to beneficiaries with health challenges and SCAN believes that Congress should affirm this record and make all forms of SNPs permanent.

Moving Toward Full Integration As a fully-integrated dual eligible SNP (FIDE-SNP) operating in multiple counties in California, SCAN recognizes the benefits of fully integrating the Medicare and Medicaid programs. In that light, we are fully supportive of policy changes that require D-SNPs to transition to FIDE-SNP by a date certain.

Testing a New Special Needs Plan for the Near Dual Population In the last Congress, Committee members Reps. Linda Sanchez (D-CA) and Patrick Meehan (R-PA) introduced H.R. 4212, the *Community Based Independence for Seniors Act*, which would create a Community Based Institutional Special Needs Plan (CBI-SNP) demonstration to provide targeted Home and Community Based Services (HCBS) for frail low-income, Medicare-only beneficiaries. As Members of the Committee are aware, seniors facing health challenges overwhelmingly prefer to stay in their own homes rather than entering an institution. Giving frail and medically complex Medicare beneficiaries access to HCBS will enable them to remain in their communities, improve their quality of life and prevent them from spending down their limited assets to become Medicaid eligible. SCAN strongly encourages the Committee to consider this bipartisan legislation.

Expanding the Value-Based Insurance Design Demonstration The Value-Based Insurance Design (VBID) demonstration will allow MA plans to offer supplemental benefits or reduced cost sharing that are

specially customized to enrollees with specified chronic conditions. SCAN would like to see the VBID demonstration expanded to additional states, especially California, or even, potentially, nationwide. We believe the ability to further tailor benefits to the specific needs of vulnerable beneficiaries will result in increased access to needed care, higher care regime adherence rates and greater ability to remain living in the community.

Allowing Additional Benefit Flexibility SCAN supports allowing MA plans the ability to go beyond the traditional, and sometimes outdated, fee-for-service benefit structure by offering non-medical benefits as part of the supplemental benefits they provide to their enrollees. Benefits such as housing assistance and nutrition-related services, as well as other social services, have shown to help improve the overall well-being and health status of beneficiaries with chronic conditions. This new flexibility will allow health plans the ability to tailor services to the unmet needs of beneficiaries and address multiple factors like functional and socio-economic status.

Expanding the Utilization of Telemedicine Services Medicare beneficiaries would greatly benefit from an expansion of telehealth within the Medicare program. Telemedicine can be a vital tool in monitoring patients with chronic conditions and can provide the means for doctors to monitor frail seniors and deliver early warning of a deterioration of function. Expanding access to telemedicine in a responsible manner makes sense because it expands access to care for beneficiaries, gives medical providers real-time data about their patients, and thus improves care itself.

Ensuring Adequate and Accurate Payment for Complex Beneficiaries It is imperative that MA plans are accurately and fairly compensated for the care management provided to medically complex beneficiaries. Research has shown that the current risk model used by CMS underpays MA plans for the costs of treating individuals with multiple chronic conditions¹. The *Affordable Care Act* authorized CMS to apply a frailty payment for beneficiaries in a FIDE-SNP who have a similar level of frailty as individuals in a PACE program. The primary policy goal of this provision was to help avoid long term institutional care for dual eligible beneficiaries. Given that this is a shared goal among all of the SNP population, it is our belief that I-SNP and C-SNP beneficiaries should be eligible for a frailty adjustment payment if they meet the same clinical criteria.

Thank you for allowing SCAN to submit this statement for the record. We look forward to working with the Committee members to advance our shared goals.

Sincerely,

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¹ Avalere Health, "Analysis of the Accuracy of the CMS-Hierarchical Condition Category Model" January 2016.



SNP Alliance

A National Nonprofit Leadership Organization

The National Voice for Special Needs and Medicare-Medicaid Plans

June 21, 2017

Chairman Kevin Brady
Ways and Means Committee
1102 Longworth House Office Building
Washington, DC 20515

Chairman Pat Tiberi
Ways and Means Subcommittee on Health
1104 Longworth House Office Building
Washington, DC 20515

Ranking Member Richard Neal
Ways and Means Committee
1102 Longworth House Office Building
Washington, DC 20515

Ranking Member Sander Levin
Ways and Means Subcommittee on Health
1139 Longworth House Office Building
Washington, DC 20515

Dear Chairman Brady, Ranking Member Neal, Chairman Tiberi, and Ranking Member Levin:

I am writing on behalf of the 26 members of the Special Needs Plan (SNP) Alliance to thank you for holding a hearing on the status of Medicare Advantage Plans (MA), including Special Needs Plans, designed to deliver integrated and coordinated care for our nation's most vulnerable seniors and people living with disabilities. As the only national organization exclusively focused on improving policy and performance for SNPs, we give special regard for the re-engineering of care for beneficiaries with multiple, complex and ongoing chronic care needs, and the integration of Medicare and Medicaid to better serve beneficiaries who are dually eligible. Until our nation comes to grips with the complex, interdependent and ongoing care requirements of beneficiaries who are poor, frail, disabled and chronically ill — SNPs' primary focus — we will not achieve better quality and cost outcomes.

The SNP Alliance supports three actions to better improve health and health outcomes for these beneficiaries. Congress should:

1. Permanently authorize all SNP types;
2. Strengthen the ability of CMS, states and plans to better align Medicare and Medicaid policies and procedures for the 10 million beneficiaries who are dually eligible for these programs; and
3. Encourage CMS to improve performance metrics for documenting quality and cost performance, with regard to functional and care complexity and the adverse influences of social risk factors that uniquely impede the health and healthcare outcomes for beneficiaries dually eligible for Medicare and Medicaid.

Permanency for All SNP Types

Currently, SNPs are set to expire in December 2018. SNPs have been temporarily extended for a few years at a time since 2003. Now is the time for Congress to make all SNP types permanent. It is our understanding that the Congressional Budget Office (CBO) score for SNP provisions contained in the CHRONIC Care Act (S. 870)...unanimously passed by the Senate Finance Committee...assumed there would be no Medicare cost and minimal Medicaid cost for a permanent extension of all types of Special Needs Plans.

Permanent SNP authority—combined with policy changes—would create stability for beneficiaries and their families, enable Congress to build upon plans that are grounded in the principles of chronic illness care, and give more certainty to states seeking to integrate Medicare and Medicaid for dually eligible beneficiaries. It would also give plans a sense of stability to invest in high value, innovative programs and benefits. In the current temporary SNP extension environment, some states are reluctant to invest in integration efforts. We also believe that proper alignment of Medicare financing, administrative and oversight requirements would reduce significant and unnecessary administrative burden and costs for government and plans, with additional improvements in total quality and cost performance.¹²

SNPs are uniquely structured to care for the growing number of frail, disabled, and chronically-ill beneficiaries, who are the fastest growing and most costly segment of the Medicare population. Such plans are designed to address these beneficiaries because:

- **SNPs go beyond the offering of traditional MA benefits and services** and maintain a model of care, provider networks, and team-based care management practices that are tailored to the population of beneficiaries they enroll.
- **The capitated financing structure of SNPs enables them to reorder traditional patterns of care to coincide more fully with the unique combination of care requirements of individual enrollees.** SNPs have an incentive to look at a beneficiary's TOTAL array of care needs, reorder the balance of what is provided and the relationship among related providers, and provide whatever combination of care is most cost effective. This is not only true for beneficiaries with Medicare-only requirements, but for beneficiaries in need of an ongoing array of Medicaid services as well. SNPs have the unique ability to reduce if not eliminate cost shifting between the Medicare and Medicaid programs, and among related care providers and enable more appropriate benefits and program design for beneficiaries living with multiple, complex and ongoing care requirement.
- **There is a national network of SNPs already in place for building the next generation of care for complex patients.** Currently, 583 Special Needs Plans provide specialty care arrangements to nearly 2.4 million beneficiaries. These include SNPs that specialize in care of beneficiaries with certain diseases, such as diabetes, End Stage Renal Disease (ESRD), Severe and Persistent

¹ A study conducted by RTI International and the Urban Institute and published by the Assistant Secretary of Planning and Evaluation, U.S. Department of Health and Human Services, found that before and after controlling for differences in characteristics, dually eligible seniors enrolled in the same D-SNP plan sponsor for both Medicare and Medicaid managed care services under the integrated Minnesota Senior Health Options (MSHO) program, experience fewer hospitalizations and ED visits than those enrolled only in the Medicaid managed long term care program without enrollment in the D-SNP. MSHO enrollees were 48% less likely to have a hospital stay, and if so, had 26% fewer stays. MSHO enrollees were also 6% less likely to have an outpatient ED visit, and if so, had 38% fewer visits. At the same time, MSHO enrollees had a higher prevalence of primary care use, higher levels of in-home home and community based services, similar levels of nursing home use and were very unlikely to opt out of MSHO while those in the non-integrated Medicaid managed care plan were more likely to choose to enroll in MSHO over time. Anderson, W., Feng, Z., Long, S. (March 2016). Minnesota Managed Care Longitudinal Analysis. Accessed at <https://aspe.hhs.gov/report/minnesota-managed-care-longitudinal-data-analysis>

² Some SNP Alliance diabetes C-SNP plans achieve lower readmission rates, have more members participate in disease management programs, and have more members with blood pressure readings below 14-/80 than non-SNPs. The Commonwealth Fund, Case Study, CareMore: High-Need, High-Cost Patients, Martha Hostetter, Sarah Klein, and Douglas McCarthy, March 2017.

Mental Illness (SPMI), and HIV-AIDS (C-SNPs); SNPs specializing in care of beneficiaries in need of nursing home and beneficiaries living in the community with similar needs (I-SNPs); and beneficiaries dually eligible for Medicare and Medicaid (D-SNPs).

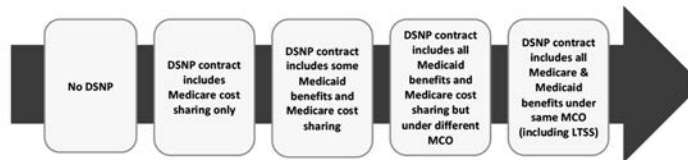
- **More than 85% of SNP enrollees are beneficiaries dually eligible for Medicare and Medicaid,** many of whom have disabilities and social factors that complicate clinical care. Many of those currently served by SNPs not only need an extensive amount of care right now, but they will need an expanded array of medical services for the rest of their lives, much of which is more complicated than what is seen by traditional Medicare and regular MA plans. SNPs provide a natural foundation for facilitating the delivery of high-quality care, improve care transitions, produce stronger patient outcomes, increase program efficiencies, and contribute to an overall effort that will reduce the growth in Medicare spending over time.

Strengthening Alignment of Medicare and Medicaid

Our nation cannot afford to maintain duplicative and conflicting administrative, financing, and delivery structures in serving our nation's most vulnerable and costly beneficiaries, where payment methods and related regulatory structures incite cost shifting, engender waste, and ignore the financial interdependencies between Medicare and Medicaid in seeking to improve total quality and cost performance. To effectively service dually eligible beneficiaries, our nation currently spends more than \$350 billion a year, comprising about 40% of Medicaid and 30% of Medicare spending.

In 2003, Congress laid an important foundation for advancing dual integration by establishing Dually Eligible SNPs (D-SNPs), building on a prior history of national demonstration. It later added a set of requirements for D-SNPs to contract with State Medicaid agencies for the coordination of Medicare and Medicaid benefits and services and establish an important model of care and care management capabilities. In 2010, Congress took another step toward advancing integration by requiring CMS to establish the Medicare-Medicaid Coordination Office (MMCO) to more effectively integrate benefits, and improve the coordination between the Federal Government and states. The goal was to ensure access to quality services for individuals who are enrolled in both programs. In 2011, CMS made additional strides for addressing Congressional integration interests by launching the Medicare-Medicaid Financial Alignment Demonstration to test, in partnership with states, new program integration models.

Today, over 85 % of Special Needs Plan beneficiaries are dually eligible for Medicare and Medicaid. Nearly two million dually eligible beneficiaries are served by Dually Eligible SNPs (D-SNPs) that exclusively serve dually eligible beneficiaries through an array of coordinated/integrated care arrangements. Over 250,000 dually eligible beneficiaries are served through Fully Integrated SNPs, known as FIDE SNPs. FIDE SNPs offer the most advanced form of plan integration. As a whole, D-SNPs provide a continuum of coordinated care opportunities for dually eligible beneficiaries and a platform for advancing fully integrated programs over the long term. (See illustration below.)



In advancing dual program integration it is important to note that all D-SNPs offer coordinated and/or integrated support that goes well beyond what is available through Medicare fee-for-service, general MA plans, or Medicaid only managed care plans. There are benefits to individuals, states, CMS, and providers at all points along the D-SNP continuum, including in the lesser, integrated models (e.g., providing the state with line-of-sight into an individual's Medicare experiences; decreasing CMS costs and state cost-sharing liability as Medicare costs are contained; providing enhanced and tailored benefits to individuals). Additionally, leveraging the full continuum of integration allows states and D-SNPs to better meet the specific needs of the target duals population, as the population is diverse. For example, individuals with LTSS needs will benefit from services that are less critical to a non-LTSS individual; similarly, partial duals will have different needs than full duals.

We recognize that the greatest benefit is realized with higher levels of integration, and the SNP Alliance strongly supports the advancement of integrated care for complex beneficiaries as fully and as quickly as possible. However, it is critical to keep in mind that current payment methods, program policies, and oversight requirements for serving dually eligible beneficiaries are deeply rooted in structures, methods, and a culture that reinforce use of separate and often misaligned program requirements and incentives. SNP programs seeking to advance dual integration along the full continuum, including for lesser or higher integrated products, are still faced with the daunting task of trying to align Medicare and Medicaid structures and procedures amidst a system that defies alignment, and lacks arbiters with authority to make operational decisions to support integration at sub-regulatory levels.

It is virtually impossible for D-SNPs to offer integrated care without aligned financial incentives, policies and program oversight requirements. Without better alignment, plans specializing in care of dually eligible beneficiaries are forced to use inefficient operating systems due to nonaligned, conflicting and confusing oversight from state and federal levels. Furthermore, efforts to integrate care within this non-aligned system often lead to increased administrative burdens for D-SNPs as states duplicate CMS requirements.

The CMS Medicare-Medicaid Coordination Office (MMCO) and others in key leadership within the Medicare and Medicaid programs have made heroic and important progress in aligning financing, policy and oversight for dually eligible beneficiaries, but significant work is still needed. CMS and States, for the most part, still administer Medicare and Medicaid benefits and services for dually eligible beneficiaries through totally different administrative structures resulting in system fragmentation and increased administrative burdens on health plans and providers. While some states have been involved in dual integration efforts for decades, many states still do not have the capability to advance integrated policy and oversight necessary for SNPs to establish and manage fully integrated programs.

Authority to enroll duals for both Medicare and Medicaid into matching plans under one plan sponsor is a critical first step toward successful integration, but it is only a first step. SNPs and MMPs cannot successfully integrate all Medicare and Medicaid unless states have the capacity to manage a fully integrated program. And, states actively engaged in advancing a fully integrated program cannot be successful in their efforts without the kind of federal-state partnership necessary for eliminating the pervasive duplication and conflicts involved in Medicare and Medicaid payment methods, program policy, and oversight.

The SNP Alliance recommends that Congress empower the CMS Medicare-Medicaid Coordination Office (MMCO) to serve as the dedicated CMS contact point to assist states in addressing D-SNP Medicare-Medicaid misalignment. In this role MMCO should be given the authority to work with states to:

- Align procurement and contracting schedules and processes between CMS and states;
- Coordinate enrollment processes and align enrollment, including use of a single enrollment card when feasible;
- Enable joint CMS and state review of member materials and coordinate member notices and communications;
- Integrate plan assessments and model of care requirements;
- Align program oversight, performance measurement, data collection and reporting, and consumer protections;
- Align payment incentives;
- Permit modification of care plans to better serve enrollees' needs; and
- Extend integration opportunities for C-SNPs and I-SNPs that mostly serve dual-eligible beneficiaries.

The SNP Alliance also recommends that CMS be required to establish procedures by April 1, 2020 that would unify the Medicare and Medicaid managed care grievance and appeals procedures applicable to D-SNPs, consistent with provisions outlined in the CHRONIC Care Act of 2017 (S. 870).

Pathways to Permanency

The SNP Alliance believes that SNPs should continually improve plan performance while advancing dual integration and care arrangements for high-risk/high need beneficiaries. We support the benchmarks for permanency as contained in the CHRONIC Care Act of 2017 and recommend, in principle, the following:

- C-SNPs should be—
 - Afforded at least as much flexibility that is being proposed for all MA plans under a nationwide extension of the Value-based Insurance Design (VID) initiative in crafting specialized benefits and services for subpopulation targeted by C-SNPs;
 - Monitored using measures and methods that are directly applicable to, and of importance for, providing special care arrangements for the population targeted by C-SNPs;
 - Required to go beyond standard MA practice for a comparable population to the extent they are provided the flexibility, and with appropriate incentives, to do so.
- D-SNPs should be—
 - Allowed to use compatible and/or integrated plan processes in administering Medicare and Medicaid benefits and services for dually eligible beneficiaries enrolled.
 - Required to advance dual integration to the fullest extent possible and to the level appropriate for the specific duals population, given prevailing state law and contracting arrangements, as well as CMS and state capability for supporting an integrated program to evolve.

Enhance Performance Measurement

The SNP Alliance believes that further adjustments to the MA Star Rating system are needed. Current

measures do not adequately match the characteristics of the dually eligible beneficiary population. The dual beneficiary population is diverse. Subgroups within the duals include persons age 18-64 with physical disabilities and behavioral health needs, persons age 85+ with multiple chronic conditions and functional limitations, individuals with late stage dementia, ALS, MS, Parkinson's disease, and others.

The current CMS Star Rating system has one set of measures for all Medicare beneficiaries—the active retiree with high socioeconomic status has the same measures as the homeless elder living with five chronic conditions. Moreover, measures are not adjusted for social risk factors, functional or condition complexity, or other characteristics of the beneficiary that are known to fundamentally affect health status (e.g., health literacy, primary spoken language). By incorporating population stratification and plan stratification, like groups of people and like health plans will be compared to each other—not compared to a global average which has little meaning. Revisions to Star measures and the methods for collecting information from the beneficiaries will go far in enhancing the utility of the quality reports that are the result of measurement.

The goal is to be accurate, meaningful, and fair. The goal is to recognize high quality and identify areas of poor quality so that quality can be improved. We urge attention to these issues within Stars so that measurement and public reporting provides useful information. There are two compelling reasons to do so. First, that beneficiaries with more complex needs are not disadvantaged or misled by the Star Ratings system. Second, that the providers and plans that disproportionately serve low-income, complex, diverse, and dual populations are not harmed by the quality measurement system which currently tends to reward providers and plans that already serve those at higher income levels and in geographic areas that are rich in resources

Research has demonstrated the role of social determinants of health, such as income, education, occupation, and social supports as significant contributors to health outcomes.³ The 2002 Institute of Medicine report titled, *"The Future of the Public's Health in the 21st Century,"* observed "research has increasingly demonstrated the important contributions to health of factors beyond the physical environment, medical care, and health behaviors, e.g., socioeconomic position, race and ethnicity, social networks and social support, and work conditions, as well as economic inequality and social capital."⁴ A large meta-analysis seeking to assign weights to determinants of health found that, on average, access and quality of clinical care contribute about 20 percent to health outcomes, while social and economic factors such as education, income and family/social supports contribute 40 percent. Health behaviors such as alcohol and drug abuse contribute 30 percent to health outcomes.⁵

In 2015 and 2016 the National Academies Committee on Accounting for Socioeconomic Status in Medicare Value-based Payment Programs conducted a thorough examination of socio-economic and social determinants of health risk factors (called "social risk factors") and found many impacted outcomes and should be taken into account in quality measurement and value-based payment.

In December 2016, the Assistant Secretary for Planning and Evaluation (ASPE) released their Report to

³ Booske, B., Athens, J., Kindig, D., Park, H., Remington, P. Different perspectives for assigning weights to determinants of health, County Health Rankings Working Paper, University of Wisconsin Population Health Institute, February 2010.

⁴ The Future of the Public's Health in the 21st Century, Institute of Medicine, 2002.

⁵ County Health Rankings & Roadmaps, University of Wisconsin Population Health Institute. Accessed at <http://www.countyhealthrankings.org/our-approach> on October 10, 2014.

Congress and found that dual-eligibility status was the most significant predictor of poor health outcomes as measured by the Medicare Star Ratings system. Furthermore, dual status, low-income status, and disability status (used as proxies for SES and other social risk factors) impacted outcomes— independent of plan or provider behavior/actions.

Members of Congress from both sides of the aisle have urged CMS to modify the Star Ratings system to better account for the clinical complexity, functional and socio-demographic risk factors that are out of a plan's control, arguing that the MA performance measurement should accurately reflect the challenges in caring for a more vulnerable population, including low-income chronically ill beneficiaries, those living in poor rural or urban areas, and those with high functional, behavioral, and medical needs.

CMS recognizes that risk adjustment is needed “because the existence of risk factors before or during healthcare encounters may contribute to different outcomes, independent of the quality of care received.”

In 2016 CMS implemented a “Categorical Adjustment Index” to better account for these concerns; however, two years of data are showing that the CAI methodology is inadequate. First, it has been applied to just 6 of the 47 measures and with minimal effect on the overall problem. Second it does not stratify plans by plan type, nor populations for social risk factors.

Another concern is the lack of guidance to measure developers to test and revise their measure specifications (definitions, exclusions, modifications) for social risk factors, functional status, complexity, etc. CMS has instead advised that measure developers should, on their own and in their own way determine if patient/individual social determinants of health should be accounted for in their measure to accurately capture performance.

The SNP Alliance recommends that Congress:

- Require CMS to adequately adjust the Star Ratings for social risk and other key complexity/functional factors, such as by stratifying measures by plan type (e.g. comparing D-SNPs to each other). Recent research by ASPE proves an inequity in the Star Rating program for plans that enroll low-income beneficiaries. The Star Rating program must account for social risk factors to accurately measure these plans' quality of care.
- In the interim, Congress should direct CMS to adjust the plan all-cause hospital readmission measure for social risk factors, and require CMS to modify the HOS survey instrument and data collection methods to improve validity and reliability for individuals who do not speak English, have low levels of health literacy/education, or significant levels of cognitive/memory impairment.
- The Star Ratings should also include quality measures that are relevant to the populations served by SNPs (e.g. beneficiaries with HIV/AIDS or those with severe and persistent mental illness) and assure that HOS and other self-report measures and methods fully account for race, culture and ethnic differences as well as differences related to beneficiaries with cognitive and mental impairments.

Again, we commend the Ways and Means Committee for its efforts to review the status of Medicare Advantage programs, including SNPs, in their effort to deliver integrated and coordinated care for our

most vulnerable seniors and people living with disabilities. We applaud Congress for having advanced opportunities for SNPs to specialize in care of these beneficiaries. We look forward to working with you as you consider next steps for the next generation of Special Needs Plans.

Best regards,



Rich Bringewatt
President and CEO
SNP Alliance

Statement Submitted for the Record

"Promoting Integrated and Coordinated Care for Medicare Beneficiaries"
House Ways and Means Health Subcommittee Hearing on Medicare Advantage
June 7, 2017

Dear Chairman Tiberi and Ranking Member Levin,

Congratulations on an excellent hearing and thank you for coming together at this time to focus on improving the lives of Medicare beneficiaries. The Center for Elder Care & Advanced Illness (CECAI) is a health services research organization, working on systems change in the public interest. We focus on designing, implementing and scaling policy solutions that are needed to adequately address the health and social services challenges facing us during the 21st century, as the nation rapidly ages. We work particularly on cost-effective program and delivery system adaptations aimed at ensuring that all of us can live comfortably and meaningfully in old age -- either at home or another setting of choice -- and at a sustainable cost to our families, to the community, and to taxpayers.

Expansion of the Program of All-Inclusive Care for the Elderly (PACE), as discussed during the hearing, is one of our policy priorities. The program has a proven track record of offering the highest quality of care to a frail and elderly population of Medicare and Medicaid beneficiaries, who have both chronic conditions and functional limitations. PACE programs provide services to seniors living in the community in 31 states, in both urban and rural areas. While PACE organizations have traditionally served a small population, they are gaining broader recognition due to their patient-centered and community-based model, and are quickly becoming the gold standard for Medicare beneficiaries who are elderly, frail, and disabled. With careful legislative guidance, PACE will be able to expand and scale to serve a larger proportion of the aging American population. In short, PACE is a health care model that offers an unusual combination of superior quality and cost effectiveness for beneficiaries, states and the federal government.

We agree that the regulations now governing PACE organizations need to be updated to maximize their benefit and effectiveness. To that end, we support the need to strongly encourage the Centers for Medicare and Medicaid Services (CMS) to launch PACE expansion demonstration programs authorized under the PACE Innovation Act of 2015 this year. We also support the three actions that Cheryl Wilson highlighted in her testimony: (1) letting Medicare-only beneficiaries enrolled in PACE to choose a Part D plan outside of a PACE organization, (2) giving PACE organizations flexibility to set premiums for Medicare-only beneficiaries, and (3) letting PACE organizations contract directly with Medicare.

The first improvement of allowing Medicare-only beneficiaries enrolled in PACE to choose a Part D plan outside of a PACE organization is vital to increase the effectiveness of the PACE model. Currently, dually eligible PACE enrollees do not pay premiums, deductibles, copayments and other costs and do not have a choice of Part D plans. A typical PACE Part D premium costs more than \$700 per month, which is about 10 times more than Part D premiums in stand-alone plans. Medicare-only PACE enrollees, who are responsible for paying their Part D premium out-of-pocket, should have the freedom to choose among available Part D plans, which will necessarily be affected by various factors including the composition of the formulary, premium amounts, and other factors. Beneficiaries who enrolled as Medicare-only and later became eligible for Medicaid could switch to the PACE Part D plan, which receives the low-income support from Medicare.

The authorizing PACE statute was enacted in 1997, pre-dating enactment of prescription drug coverage under Part D for all Medicare beneficiaries in 2003. The interpretation of the PACE statute and the statute and regulations covering Part D result in the odd outcome of having Medicare-only beneficiaries being the only Medicare-covered persons who pay full price for their drug coverage, without ever becoming eligible for the federal government subsidy of catastrophic costs or manufacturer discounts in the donut hole. A possible solution is to amend the PACE authorizing statute to allow Medicare-only PACE enrollees to purchase a Part D plan in the marketplace and to pay co-pays and deductibles on this plan.

The second improvement -- giving PACE organizations the flexibility to set fair premiums for Medicare-only beneficiaries -- is essential for broad expansion and scaling. While the PACE authorizing statute calls for "capitated, integrated funding that allows the provider to pool payments received from public and private programs and individuals," it is silent on the amount of private payment that Medicare-only nursing home level of care enrollees should be charged for long-term services and supports (LTSS).

Because PACE has long been viewed as a program serving dually eligible beneficiaries, current regulations offer Medicare-only beneficiaries only a single option for using their own private funds to buy into the program. Current regulations require that the premium be the full Medicaid capitation rate, which is an average rate; at present the national average is about \$2300 per month. This amount may be too high for many Medicare beneficiaries, because they may initially have more limited LTSS support needs. Moreover, Medicare-only beneficiaries and their families are often unfamiliar with LTSS costs, and the high single monthly rate can appear daunting. A more flexible tiering approach may prove to be more readily understandable to Medicare-only beneficiaries and their families -- which is important, because making a choice of financing must be made at time of enrollment. Providing an opportunity to pay either tiered premiums for graduated services packages according to assessed need, or a premium equal to a state's PACE Medicaid average capitation rate, would substantially enhance the ability of Medicare-only beneficiaries to make thoughtful choices about how to finance their LTSS services.

The third proposed action, of letting PACE organizations enter into two-way contracts with Medicare, is necessary to increase enrollment of Medicare-only enrollees. It may also slow spend-down to Medicaid. Currently, PACE program agreements for Medicare-only enrollees are not discussed explicitly in either the authorizing statute or in regulations. Yet some Medicare-only beneficiaries are currently enrolled in PACE programs, and CMS' website at medicare.gov acknowledges this.

Today, Medicare beneficiaries wishing to enroll in PACE cannot do so in 19 states that do not have PACE as an option under their Medicaid program. To slow spend-down, states that are now planning strategically for the "age wave" may wish to see PACE plans established quickly that can serve Medicare-only enrollees. Additional flexibility permitting expanded plan choice for Medicare-only beneficiaries across the country is therefore prudent.

Our team at the Center for Elder Care & Advanced Illness is working on multiple fronts to create workable reform proposals that will enable reliable and comprehensive support that includes both medical care and LTSS with mixed private and public financing that includes Medicare, Medicaid, the Older Americans Act and related programs. We have developed a population health proposal focused on frail elders, whose numbers are quickly rising. This proposal, which we call MediCaring Communities, is solidly grounded in evidence and experience, and we would be pleased to discuss it with the Committee. There really is a way for communities to assume a leading role in helping to solve the challenges of an increasingly long-lived population. Expanding PACE is an important part of executing such a strategy.

We hope the historically bipartisan support for PACE in the past and its applicability across often divided constituencies will make these suggested solutions attractive legislative goals. We appreciate the

opportunity to submit these comments, and would welcome any opportunity to assist the Committee moving forward.

Sincerely,

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